S. Hrg. 102-370

MEDICARE CAPITAL PAYMENT POLICY

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JULY 11, 1991

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

48-319 ⇆ WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-037197-X

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, Jr., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM DASCHLE, South Dakota
JOHN BREAUX, Louisiana

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
DAVE DURENBERGER, Minnesota
STEVE SYMMS, Idaho
CHARLES E. GRASSLEY, Iowa
ORRIN G. HATCH, Utah

Vanda B. McMurtry, *Staff Director and Chief Counsel*
Edmund J. Mihalski, *Minority Chief of Staff*

Subcommittee on Medicare and Long-Term Care

JOHN D. ROCKEFELLER IV, West Virginia, *Chairman*

LLOYD BENTSEN, Texas
MAX BAUCUS, Montana
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
TOM DASCHLE, South Dakota

DAVE DURENBERGER, Minnesota
BOB PACKWOOD, Oregon
BOB DOLE, Kansas
JOHN H. CHAFEE, Rhode Island
JOHN C. DANFORTH, Missouri

Public Laws: 102nd Congress / 1st Session / Senate Hearings / 1991

CONTENTS

OPENING STATEMENTS

	Page
Rockefeller, Hon. John D., IV, a U.S. Senator from West Virginia (chairman of the subcommittee)	1
Durenberger, Hon. Dave, a U.S. Senator from Minnesota	2
Daschle, Hon. Tom, a U.S. Senator from South Dakota	4
Breaux, Hon. John, a U.S. Senator from Louisiana	4
Hatch, Hon. Orrin G., a U.S. Senator from Utah	13

COMMITTEE PRESS RELEASE

Medicare Capital Payment Policy Hearing Scheduled; Finance Subcommittee to Hear Testimony on HCFA Proposal	1

ADMINISTRATION WITNESS

Wilensky, Hon. Gail R., Ph.D., Administrator, Health Care Financing Administration	4

CONGRESSIONAL WITNESS

Altman, Stuart H., Ph.D., Chairman, Prospective Payment Assessment Commission, Washington, DC	18

PUBLIC WITNESSES

Owen, Jack W., interim president, American Hospital Association, Washington, DC	27
Bromberg, Michael D., executive director, Federation of American Health Care Systems, Washington, DC	29
Smith, Judith P., president and chief executive officer, Daughters of Charity Health Services of Austin, Austin, TX, representing the Catholic Health Association	31
Dalston, Jeptha, Ph.D., president and chief executive officer, Hermann hospital, Houston, TX, representing the American Association of Medical Colleges	43
Lugar, Thomas, chairman of the board, Methodist Hospital of Indianapolis, Indianapolis, IN, representing the American Protestant Health Association	47
Wilson, Donald A., president, Kansas Hospital Association, Topeka, KS	49

ALPHABETICAL LISTING AND APPENDIX MATERIAL SUBMITTED

Altman, Stuart H.:	
Testimony	18
Prepared statement	61
Responses of Stuart H. Altman to questions submitted by Senator Rockefeller	68
Bentsen, Hon. Lloyd:	
Prepared statement	69
Breaux, Hon. John:	
Opening statement	4
Bromberg, Michael D.:	
Testimony	29
Prepared statement	69
Chafee, Hon. John H.:	
Prepared statement	72

Page

Dalston, Jeptha:
Testimony 43
Prepared statement 73
Daschle, Hon. Tom:
Opening statement 4
Durenberger, Hon. Dave:
Opening statement 2
Hatch, Hon. Orrin G.:
Opening statement 13
Lugar, Thomas:
Testimony 47
Prepared statement 80
Owen, Jack W.:
Testimony 27
Prepared statement 86
Rockefeller, Hon. John D., IV:
Opening statement 1
Smith, Judith P.:
Testimony 31
Prepared statement 91
Wilensky, Hon. Gail R.:
Testimony 4
Prepared statement 97
Responses of Gail R. Wilensky to Senator Moynihan's questions 102
Wilson, Donald A.:
Testimony 49
Prepared statement 104

COMMUNICATIONS

Association of Freestanding Radiation Oncology Centers 108
Greater New York Hospital Association 109
Healthcare Financial Management Association 112
Kinetic Concepts, Inc. (KCI) 118
National Council of Health Facilities Finance Authorities 124

MEDICARE CAPITAL PAYMENT POLICY

THURSDAY, JULY 11, 1991

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:15 p.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Bentsen, Baucus, Daschle, Breaux, Durenberger, Chafee, and Hatch.

[The press release announcing the hearing follows:]

[Press Release No. H-26, July 3, 1991]

MEDICARE CAPITAL PAYMENT POLICY HEARING SCHEDULED, FINANCE SUBCOMMITTEE TO HEAR TESTIMONY ON HCFA PROPOSAL

WASHINGTON, DC—Senator John D. Rockefeller IV, Chairman of the Finance Subcommittee on Medicare and Long-Term Care, Wednesday announced a hearing on Medicare hospital capital payment policy.

The hearing will be at *2 p.m. Thursday, July 11, 1991* in Room SD-215 of the Dirksen Senate Office Building.

Rockefeller (D., West Virginia) said the Subcommittee will hear testimony regarding the Health Care Financing Administration's (HCFA) proposed regulation to institute a prospective payment system for inpatient hospital capital costs under the Medicare program. "Last February, the Health Care Financing Administration issued its proposal for a prospective payment system for hospital capital costs under Medicare. This hearing will provide an opportunity to explore HCFA's proposed rule in depth and to hear from interested parties on how the proposed rule would affect hospital spending on capital and hospitals' overall financial condition," Rockefeller said.

Witnesses will include Dr. Gail Wilensky, HCFA Administrator, and Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. I apologize for being late. There is a first time for everything. I was presiding over the Senate, which is an experience so prestigious and august that I got swept away and left late.

Senator DASCHLE. Did it have anything to do with being called Mr. President? [Laughter.]

Senator ROCKEFELLER. I refuse to believe that I am blushing. [Laughter.]

I am extremely pleased to be holding this hearing on hospital capital payment policy, a subject well-known by all Americans. After years of debate and discussion on this, it appears that we are

closer, in fact, than we ever had been to actually folding capital into the prospective payment system.

I commend, as I always do, as a matter of article, faith and self-preservation, Dr. Gail Wilensky for her incredibly hard work—and I mean that. She presides over that department in a way that I have never seen done so effectively. I commend her for her hard work in developing a regulation that addresses many of the major issues and the problems which caused Congress to delay a prospective payment system for hospital capital, not once, but twice in the past. But a few main issues still remain, and that is why we are holding today's hearings.

Attempts to moderate the cost of health care have proven to be tricky, frequently elusive, and always controversial. Unfortunately, there are no easy solutions to cost containment.

When the Medicare program first moved to a prospective payment system in 1983, changes in hospital behavior did, in fact, occur, and the rate of growth of Medicare hospital expenditures slowed.

The goal of folding capital into the prospective payment system is not solely to lower health care costs, rather, the goal is to rationalize payments so that there are not strong financial incentives to buy unneeded or duplicative equipment, for example, or to build a new wing because reimbursement for capital expenditures is done on a cost basis. Folding capital into the prospective payment system is meant to give the right incentives to hospital administrators when trying to decide whether to expand or to buy new equipment.

At the same time, a delicate balance needs to be struck between providing the right incentives for capital decisions, and making it financially impossible for a hospital to buy needed equipment or renovate or replace an aging facility.

So, this is a very important hearing. I would welcome—I do not have the order of appearance—but certainly, Senator Durenberger, if you have any statement or comments, or any of our other distinguished colleagues.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much. I would like to begin by congratulating Dr. Wilensky and her staff, as you have, for a job well done on this regulation.

Over the past month, in listening to the comments of various hospitals in my State and the organizations which represent them, I have heard what a thoughtful and credible job HCFA staff have done in designing this regulation.

There are some concerns on the part of institutions, to be sure, and I expect we will hear about these this afternoon. But having been through the capital wars for what seems like forever, I am pleased to see a regulation which will accomplish what we in Congress intended back at a time when we were just formulating our intentions: a fully inclusive prospectively determined rate for each Medicare admission.

Back in 1985, I introduced the Medicare Capital Payment Reform Act, a bill which directed the Secretary to adjust the national DRG prospective payment rate for each hospital to provide an add-on payment, in accordance with a specified formula, for capital-related costs. Six months later, I introduced the Fair Deal Capital Payment Act, which would have provided for a 7-year transition from reimbursing hospitals for capital-related costs based on a hospital-specific average to a national average standardized capital cost per discharge.

Well, somebody just reminded me—I think it was one of the participants—that what we have before us looks a lot like the Fair Deal Capital Payment Act, but it has 3 extra years under it.

Mr. Chairman, I believe today as I did then that the traditional Medicare capital passthrough does not provide the right incentive for hospitals to control capital expenditures, and it is contradictory to the prospective payment system.

Under our current reimbursement system, Medicare payments for capital are open-ended, while operating costs are fixed and advanced. This encourages hospitals to control their operating costs, but not their capital investments. Cost reimbursement permits hospitals to make capital spending decisions that are not necessarily logical.

Gail Wilensky has suggested that our present capital reimbursement system has fueled a medical arms race, and I think in some communities that may be the case.

Let me emphasize, Mr. Chairman, that while I am in favor of changing the financial incentives to reward economically rational purchasing behavior, I am also concerned that we do so in an orderly manner with as few casualties as possible.

In that regard, I am particularly pleased with the lengthy transition period allowed by the regulation—3 years longer than I proposed in 1986.

There are, however, a number of refinements that should be considered to further ease the transition. I believe these refinements can be made without jeopardizing the integrity of the regulation.

I think it would be appropriate for HCFA to expand its definition of old capital to include rental payments and property taxes, and to recognize yet-to-be-completed projects where a clear commitment has already been made.

I would also prefer to see an individual institution exception process that is permanent and provides greater protection for hospitals that are unable to fund necessary capital projects.

And finally, it is my hope that we can find some way within the proposed framework to accommodate the special problems faced by essential rural or inner city hospitals with especially old physical plants.

So, in closing, Mr. Chairman, just let me welcome the old friends that were around in 1985 and 1986, some of whom will be testifying. I think both Mike Bromberg and Jack Owen are on the list to testify today, and I suspect that with a little bit of luck and continued cooperation from HCFA, we will not be here in 1996 discussing this issue all over again.

Senator ROCKEFELLER. Thank you, Senator Durenberger. Senator Daschle.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. I will be real brief. It is obviously a very timely hearing, and I appreciate your leadership in this area. We have about 2½ months before the regulation goes into effect October 1.

There are some concerns, in spite of the fact that, as Senator Durenberger has expressed, I find a great deal to say in support of the regulations as they are proposed.

There are four areas of concern that I hope the subcommittee will take a look at, and that I hope we, as a Senate, will try to work with HCFA in trying to resolve the definition of old capital, whether or not it is too narrow; the definition of obligation capital; the degree of commitment with regard to that capital; the base period as it affects these regulations in particular, and just what data we are going to be using with regard to establishing the base period; the exceptions for prospective payment; and finally, the geographic adjusted. Those four concerns come up time and again as I talk to people in South Dakota and the Midwest. I would hope as we look at these regulations we will look at them from those four perspectives in particular in the hope that we can resolve the difficulties and the outstanding disagreement with regard to how they might be interpreted.

I thank you for your attention. Those are my comments for now.

Senator ROCKEFELLER. Thank you, Senator Daschle.

Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you, Mr. Chairman. I do not serve on this subcommittee, but I had missed the opportunity to see you preside in the Senate, and I just did not want to miss the opportunity of seeing you preside here in the committee hearing. [Laughter.]

So, I am here, and I thank you for letting me be here. I want to ask Dr. Wilensky about the flexibility between the hold harmless formula, and the general transition formula. They have undertaken a gigantic task.

I commend them for the proposals. Obviously, they will be taking into consideration suggestions that we make, and hopefully, we will come up with an even better set of proposals.

Thank you.

Senator ROCKEFELLER. Thank you very much.

Dr. Wilensky, as always, we are very happy and proud that you are here.

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. WILENSKY. Thank you. Mr. Chairman and members of the committee, I am pleased to be here today to discuss the Administration's proposal to implement a prospective payment system for Medicare in-patient hospital capital costs.

Cost-based reimbursement for Medicare capital is inherently inflationary, contributes to the escalating cost of health care, and im-

properly distributes health care dollars. Those who argue that the current cost-based system for capital is not a problem are just plain wrong. The capital payment system needs to be changed.

Our proposal to implement a prospective payment system for capital is an important step toward curbing inappropriate spending. Moderating the growth in health care costs is a must if we are ever to address the broader issues of health care reform. I hope you will join me in supporting the change.

Medicare capital expenditures are growing at an unacceptable rate: twice that of overall inflation. Since 1984, the cumulative cost per case for hospital capital has increased almost 100 percent, while capital input prices have grown less than 20 percent. The volume and intensity of capital acquisition far outpaces the increase in input prices for capital assets.

The current cost-based system for Medicare hospital capital payments is unfair. Under current law, Medicare pays hospitals 15 percent less than its share of costs.

Medicare capital payments, under the current system, have been restrained only through progressively deeper cuts. Discounted payments penalize all hospitals, particularly those that make prudent capital decisions.

Cost reimbursement provides no incentive to control capital spending. Medicare pays for capital regardless of how expensive or necessary the equipment, how under-used the plant, or how high the interest rate for borrowing. The more hospitals spend, the more Medicare pays.

Between 1984 and 1988, hospital admissions declined 2.7 percent annually, while total capital costs increased 9.2 percent per year. Today, over one-third of all hospital beds in this country are empty. Reimbursing hospitals to maintain under-utilized facilities provides no incentive to down-size or to convert to alternative uses, even when such actions are clearly justified.

Cost-based reimbursement continues to subsidize excess capacity because the system does not link Medicare capital payments to Medicare payments. For example, one 273 bed hospital had a total occupancy of only 36 percent. Three-quarters of that amount were Medicare patients. As a result, Medicare paid three-quarters of all the hospital's capital costs, including funds necessary to maintain the unused capacity—two-thirds of the hospital's beds.

The incentives of the current system give a green light to capital projects of marginal value. For example, one hospital added a 71 bed satellite facility. Because of the expansion, its total capital costs increased 90 percent. At the same time, Medicare patient days decreased 6 percent. The Medicare program should not continue these unjustified subsidies.

The lion's share of hospital spending is for operating costs. Capital payments represent about 10.7 percent of Medicare's total inpatient payments. Yet capital spending affects operating costs, as well. The acquisition of new technology drives up operating costs for staffing and other support services.

Technological advances have led hospitals to participate in a medical "arms race" as they strive to remain competitive.

Hospitals purchase capital equipment, but spending in other areas also increases. It is the physicians who use the new capital

equipment, and it is the physicians who bill Medicare and other payors for services.

Unnecessary capital acquisition drives up overall health spending, and all payors—business, government, and private insurers—foot the bill.

Prospective capital payment will compel hospitals to better plan how they can provide cost-effective, quality health care. Hospitals that plan appropriately and invest wisely will be able to remain up-to-date and well-equipped. This change is long overdue.

Medicare spending on hospital capital will continue to finance a modern, well-equipped hospital industry because Medicare capital funding will not be cut.

In fact, aggregate Medicare capital payments will increase from 85 to 90 percent of reasonable costs.

Moving from cost reimbursement to a prospective payment system requires a careful approach to avoid financial disruption and ensure fair treatment of hospitals in differing situations.

During the 10-year transition period, hospitals with high capital costs will be protected through a "hold harmless" payment methodology. Hospitals with low capital costs, such as rural hospitals and sole community providers, would be paid a blend of their costs and the Federal rate. We estimate that over 95 percent of hospitals with low capital costs will gain under the proposed rule, because payments will be based on an increasingly larger proportion of the Federal rate.

We are also proposing an exceptions policy to help vulnerable hospitals that serve indigent populations, and to assist hospitals that need to renovate and update in the near future.

We have made significant efforts to encourage participation in the rulemaking process. We have had frequent and extensive discussions with representatives of the hospital industry, the financial market, and also members of Congress.

We provided every Medicare participating hospital with a computer disc and a manual worksheet to enable them to analyze the impact of our proposal on their facilities. We extended the comment period by 15 days to provide more time for hospitals to develop their comments.

We are carefully reviewing the comments as we develop the final rule. They have raised several legitimate concerns. Some modifications are warranted, and we are currently evaluating the options. We plan to publish the final rule on August 30.

The most frequent comments have fallen into 2 categories: the definition of "old" capital, and the exceptions process.

Many commentors recommend expanding the definition of old capital to include leases, home office costs, taxes, and insurance. Many also recommend establishing a cut-off date to include more recent capital acquisitions or obligated capital that has not yet appeared on the cost reports.

We are analyzing these comments to determine if alternative definitions for old capital can be developed that is both fair and equitable.

Commentors also recommend an exceptions policy that does not use Medicare margins in determining exceptions for sole community hospitals and for certain urban hospitals.

Many recommend that there be an permanent exceptions policy. Some see the need for a more flexible policy that would allow for exceptions due to extraordinary circumstances. Others prefer to substitute a payment floor for all of the exceptions policy.

The proposed Federal payment adjustments also have engendered a number of comments. Recommendations address the use of the hospital wage index as a proxy for variations in construction costs; the age of physical plant; the addition of medical equipment adjustment; and a more generous adjustment for urban hospitals serving low-income patients.

We will closely monitor the impact of the capital regulation following its implementation, and welcome the ongoing involvement of hospitals, ProPAC, and others. Once experience is gained, we will look forward to some fine tuning.

The task before us is to implement prospective capital payment. Our extensive efforts over the past year, as well as those that have been underway to develop a final regulation, will produce a solid prospective payment system for capital.

Thank you. I am happy to answer any questions you may have. [The prepared statement of Dr. Wilensky appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Dr. Wilensky. As you know, the majority of rural hospitals have capital costs below the national average and, as a result, are likely to fare well under the proposed capital regulation.

In fact, West Virginia hospitals have spent far less on capital, when compared to other hospitals on a regional basis, or even more so, on a national basis.

On the other hand, West Virginia's average age of its physical plants is ranked 13th nationally. Only 12 States, therefore, have an average physical plant age that exceeds West Virginia's.

The notion of a prospective payment system for capital is to provide payment for capital that a hospital can bank for the future, so that when a hospital needs to expand, or to renovate, or buy a new or replace a piece of equipment, they will have the funds to do that.

Reality, though, is that many rural hospitals are struggling just to keep their doors open. I think we have lost six hospitals in West Virginia, with about six on the edge. And any so-called "extra capital payments" are likely to go into wages and salaries, or other operating costs.

According to ProPAC, in the sixth year of PPS, rural hospitals, on average, have Medicare operating margins of minus 5.1 percent.

In the letter you wrote to all the members of the Senate Rural Caucus, you said that as long as rural hospitals continue "their prudent capital investment practices," they are likely to do fine under the proposed rule.

I would argue that their prudency has been the result of being strapped for cash. Most rural hospitals have been struggling for so long, they really have not had a chance to even consider adding new services that might be needed, much less renovating their physical plants.

How do you think rural hospitals will fare over the long-term, given their current financial conditions? Ten years from now, for example, if a rural West Virginia hospital needs to renovate an

aging wing or replace a vital piece of equipment, will they be able to afford it, keeping in mind that in rural West Virginia, a disproportionate number of their patients are Medicare patients, so Medicare's capital policy would have a disproportionate impact.

Dr. WILENSKY. I was not trying to determine the motivations for prudency in rural hospitals. I tend to agree with you that they have been prudent because they have been strapped for cash.

The fact of the matter is, however, that this payment policy will provide some support for hospitals that have been in that position, because they will receive a payment irrespective of whether they are, at that moment undergoing capital construction.

And whether they choose to use the payments for capital expenditures, or whether they choose to use it for operating expenditures will be at the discretion of the hospital administrator, as it should be, as it is for most services where there is a price that you know that you will receive for providing a service. It is up to the individual who is running the facility to make sure that ends are met with that amount of money.

With response to your specific question, I think that hospitals in West Virginia, both in the interim, and particularly at the end of the 10-year period will, indeed, be in a much better position as a result of this capital rule than they would have been under cost-based reimbursement.

The notion here is to make sure that hospitals know beforehand what it is they can expect to receive. They can put it aside, if they believe that the best use of its funds is to put aside money for expansion.

We have a number of provisions for hospitals that find, in the interim period, that they need to make expansions; such as sole community hospitals, and exceptions policies for hospitals that have not gone to the capital market for a long time and feel that they must.

I believe that our movement to a single standardized amount by 1990 for urban and rural hospitals, combined with this capital payment system will indeed help the rural hospitals of West Virginia, and will put them in a far better position than they would have been if we stayed under our present system.

Senator ROCKEFELLER. All right. I have several more questions, but our time is running. Thank you. Senator Durenberger.

Senator DURENBERGER. Dr. Wilensky, the American Hospital Association in specific, and I think probably some of the other hospital associations, recommend that the proposed rule's temporary exceptions provision be modified to include a permanent exceptions process that establishes a payment floor "safety net" set at a specific percentage of actual hospital capital costs that would represent the minimum capital payment a hospital could receive under the system.

I take it you have thought about that and rejected it, and I wonder if you would not comment on that.

Dr. WILENSKY. There are two parts to this issue. One I feel more strongly about than the other, and that has to do with the payment floor. The first part has to do with whether an exceptions policy ought to be permanent.

As of the present time, we think that the exceptions policy ought not to be permanent; it ought to be temporary. But the fact is, we have a ten-year transition period, and that provides us with a substantial amount of time to re-think whether or not in the second half or in the last 2 or 3 years whether it is appropriate to have an exceptions policy continue in the future.

So, I would like it clear for the record that, while at this point we do not think having an exceptions policy on a permanent basis is necessary or desirable, we do not want to close the door on that idea.

The part with regard to the floor is a different issue. I think that the concept of the floor flies in the face of the whole notion of a prospective payment system.

That is, a floor guarantees payment rates and has the effect, basically, of not being very different from the current cost reimbursement system. That is precisely our biggest objection.

What we have done in the exceptions policy is attempt to fashion the various circumstances which we think appropriately allow for a different treatment during the transition. For example, hospitals that suddenly find themselves with large increases in expenses; sole community hospitals; and urban hospitals serving large numbers of poor. We have also gotten some useful comments about some additions we had not thought about. We think that is the appropriate way to do an exceptions policy and not to arbitrarily say no less than 80 percent, 75 percent, or whatever. That is how we got into as much trouble as we now are.

Senator DURENBERGER. Next, would you give us some idea of your thinking on teaching hospitals? I do not see any adjustors for medical education on the capital side. Could you tell us why?

Dr. WILENSKY. The reason we did not make an adjustment for capital is that all of the adjustors were those that were empirically associated with different capital costs.

That is, we did not try to decide what we thought ought to adjust for capital reimbursement. We looked and analyzed to see what did account for variations.

In the analysis using PPS–5 data, which, when we did the proposed rule, was the latest data we had available, medical education was not a significant factor. We are re-doing the analysis. It has been raised to our attention, and we believe it ought to be included if, in fact, there is some empirical justification. We are seeing whether that is the case.

Senator DURENBERGER. My third question deals with medical technology acquisition, particularly large, expensive diagnostic equipment. It strikes me that some new pieces of new diagnostic equipment today cost as much as hospitals cost about the time I started practicing law.

Could you share with us what thoughts went through your mind about the role that a separate capital treatment for that kind of technology investment might play in controlling decisions about medical technology investment?

Dr. WILENSKY. Our interest has been to try to use overall economic incentives to have good decision-making go on in hospitals at the operating level: whether or not to expand a facility, whether or not to purchase individual technologies. We want to let the hospi-

tal know that it is going to receive only so much money per patient that it treats, and it has to decide how to best use that money in order to treat patients, stay competitive, and keep its market share.

We do not really want to get in the business of trying to decide—particularly from Washington—whether some particular hospital ought to buy an MRI or a PET scan, or something else that is about to come out as the next generation beyond the PET scan. We want to get the right economic incentive out there, and let the hospitals decide whether they should do it, whether they should share it, or whether they ought to defer for 3 or 4 years and see what their competitors do. It is a much more effective way to try to control health care costs.

We could hardly have a system in place that generates expenditures faster than the one that we now have. We do not think this is going to solve everything, but it is a step in the right direction to try to change incentives into more helpful forces.

Senator DURENBERGER. All right. Thank you. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Dr. Wilensky, we have always felt very strongly about the role sole community hospitals play in providing the 100 percent exception, and I think of all the different aspects of these regulations, the thing that concerns many of the hospitals in my State—we have a lot which are sole community providers—is that, the loss of the 00 percent. Given the fact that historically we have made a commitment, we understand their very unique importance. Is HCFA giving any consideration to maintaining that 100 percent for sole community hospitals?

Dr. WILENSKY. It is. It is a comment that we have received. We are, as we frequently find ourselves, in the position now of trying to balance changes in the definition of "old" capital, expansions in the exceptions policy, "holding harmless" in various ways for past decisions, and making sure that we have enough money for new capital for those hospitals.

But specifically, yes, we are reconsidering the issue of whether or not the exceptions policy for a sole community hospital ought to be changed.

Senator DASCHLE. What about the definition of obligated, as well? Not necessarily as it relates to sole community hospitals——

Dr. WILENSKY. I understand.

Senator DASCHLE.—but in general. Could you elaborate a little bit more on what intentions you might have with regard to that definition?

Dr. WILENSKY. Yes. The areas in which I believe we received the most comments—or at least I personally have had the most discussion about—have included what we define as "old" capital, whether it included leases and other aspects than what we had in the proposed rule, and also when it had to have existed. They are both issues that we specifically requested comments on in the proposed rule, and we got some very helpful comments in return.

We are aware that the issues of obligated capital were treated in a very conservative way in the proposed rule, and we received a

number of helpful comments about how to recognize an obligation that has been made in a very clear way, what it is that was obligated as of a point in time, say, the end of 1990, and how to protect it, if that is what we are trying to do. We are going to make changes in those aspects of the rule.

Again, we are now trying to simulate the cost of recognizing different types of obligation and different definitions to see how much money we are drawing out of the pot that will either affect the level at which we protect "old" capital, now at 90 percent. We could, of course, choose to protect it at 85 percent, which is what people presumably expected when they purchased their capital, since that is the existing rule. Or, we could try to take it out of new capital or exceptions. The issue is if we expand the definitions, where is it most equitable to take the funds from. But it is something we are definitely considering changing, and I think that it is an area that you will see changed in the final rule.

Senator DASCHLE. One of the other concerns that continues to be raised with me is that we are going to be using a base period which, by the time the regulations are promulgated, will be 3 years old. Are you looking at ways of which we might be able to improve that base period from 1988 to something more recent?

Dr. WILENSKY. Well, we will definitely be using 1989. One of the problems is that we got caught in the transition between 1988 and 1989 data, but we needed to get our proposed rule out. And so, the rule was based on 1988 data. We will use 1989 data, and we will try to update to 1990 as best we can so when we move to 1992 we have a shorter time. It is certainly our intent to use the most recent data. We are painfully aware of problems associated with using less recent data.

Senator DASCHLE. The final concern that continues to be raised in South Dakota and, I am sure elsewhere, is that there are some substantial differences in the calculation of the wage index and the calculation of capital costs. That is true in particular in our State, but it is probably true in bigger States, as well.

Is HCFA looking at ways with which to correlate the differences in the two concepts and find ways with which to resolve what, in some cases, could be a substantial disparity?

Dr. WILENSKY. We have no philosophical commitment to the wage index. At the moment, it seems to be the best proxy for capital costs that we can come up with, and definitely better than the alternative that we had available, which was a construction cost index.

We are committed to revising and using other ways to measure capital costs as soon as they are available. It simply was, as best we can tell, the best measure of variations in capital cost now available. But we will gladly change them as other data become available and accepted.

Senator DASCHLE. But for purposes of October 1, we can expect——

Dr. WILENSKY. You can expect it. It will be the wage index.

Senator DASCHLE.—that the wage index will be, without exception, the formula used in determining capital costs?

Dr. WILENSKY. To the best of my knowledge, we have not yet come up with a better definition. Were we to find one between now

and the time we have to publish the final rule, we would gladly substitute it. But, I am not aware of anything on the horizon.

Senator DASCHLE. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman, and thank you, Dr. Wilensky, for your testimony. Let me ask you. It seems to me that some of the hospitals under the proposed regulations would actually be hurt rather than helped by the "hold harmless" formula, since their capital reimbursements would actually be higher under the general transition formula.

My question is, I guess, under the regulations as you envision them to be finalized, would there be some flexibility for the hospitals to choose between whichever of the formulas they end up doing better under, or it would be a hard and fast determination?

Dr. WILENSKY. I believe that it is more likely to continue the high-cost/low-cost split. I think that some of the hospitals that were concerned that the "hold harmless" provision would not help them might find themselves in a different position as a result of changes in the definition and timing of obligated capital. But I would be glad to get back with you in some greater detail.

Senator BREAUX. Well, I really want to discuss it, because I think in an effort to try and help some of the hospitals, perhaps, we end up creating a more difficult situation and we, I think, need to explore it, perhaps, a little bit further.

Let me ask you about the binding commitment that would be required to be classified as "old" capital. I am concerned that perhaps some hospitals may not have a legally binding signed contract—and I think Senator Daschle may have been exploring this—but would have expended a great deal of legal funds or architectural fees.

A lot of work has been done in the planning on a capital project, but they have just not yet signed a legally binding construction contract, but they have done a lot of work in preparation for a capital expenditure. I guess I am just concerned that they have an economic commitment, certainly, on behalf of the hospital for the project.

That economic commitment probably compels them to complete the project, even though it is not a legally signed contract. I am wondering, what are your thoughts about how something under that situation would fit into the proposed regulations?

Dr. WILENSKY. As the proposed regulations are written, it obviously would not fit. But again, this is one of the areas we specifically mentioned in the preamble that we were concerned about, particularly in strict Certificate of Need States where there may be a long pipeline between the time planning starts and the time an actual, legal commitment or construction begins or is completed.

We indicated that one of the definitions we would be willing to consider is a substantial expenditure of funds—I think the number we used was $750,000—or some sort of legal commitment. We received a number of comments about that, and they will be addressed in the final regulation. Our main concern has been to avoid a wave of anticipatory spending and to try to define obligated capital in a way that clearly would meet a common sense definition

that it existed, and what the obligation was for, since we are protecting and holding that "harmless."

Senator BREAUX. Well, I would certainly encourage you to move in that direction. I think that what we tried to do is correct, but sometimes a legal commitment may really be a factor of less work being done on a project than an economic commitment. All these other things that I have mentioned that have already been committed to a project would really require the hospital to have an economic commitment to carrying through with it.

And then another point I would make, if we pick an arbitrary number—you mentioned $750,000 as a commitment—on a large project, that may be a very small commitment. But on a small project, it may be almost 90 percent of the whole cost of the project. And I am wondering whether you may consider, perhaps, a percentage commitment. In other words, if you have a project that is only a half a million dollar project—a small expansion—perhaps a 30 percent commitment or some figure as a percentage being spent towards that capital project, would that not be a possible way of determining whether a commitment has been made rather than just an arbitrary $750,000 amount?

Dr. WILENSKY. It is certainly possible. Again, we are looking at alternative ways to clearly establish a commitment that was made as of a date certain.

Senator BREAUX. I think we try to use common sense, but it is hard to write common sense, and I think that is what you are struggling with. I think we should be able to put all of our minds together and hopefully come up with something that does make sense and accomplish the job we are all supportive of. Thank you.

Dr. WILENSKY. We are trying.

Senator ROCKEFELLER. Thank you, Senator Breaux. I just wanted to say that I am very, very happy, as a member of the Finance Committee, that Senator Orrin Hatch is on the Finance Committee. He has a very deep commitment to health care, malpractice reform, and a whole series of areas. I think we are very lucky to have him. I just thought I would say that, Senator Hatch. Also, if you have any comments that you want to make.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Well, thank you very much for your kind remarks, Mr. Chairman. I appreciate it and I am pleased to join the discussions of this subcommittee in reviewing proposals to reimburse hospital Medicare capital expenses on a prospective payment system, and I would like to welcome Gail to the committee.

Dr. WILENSKY. Thank you.

Senator HATCH. I appreciate the tough job you have, maybe more than you think I appreciate it. I think it was awhile back I called HCFA a four-letter word. I did not use the word. I said, HCFA is a four-letter word in the eyes of many people. And it is a tough job, and I appreciate that.

I want to share with my colleagues, if I could, Mr. Chairman, my concern that this new system should provide adequate payments to individual hospitals so that they can provide services necessary to

meet the health care needs of their communities. And I have learned, for instance, from the hospitals in Utah that they are ready and willing to accept the proposals which are reasonable. However, they are very concerned that the current proposals hurt some hospitals because the rules impact is essentially unknown, and appears to be unknowable.

Given the magnitude of the shift in Medicare capital dollars that surely will be the result of this rule, there needs to be some protection for vulnerable hospitals. They suggest making the existing exemptions permanent and establishing a payment floor equal to a proportion of individual hospital capital cost, like 80 percent. Then Medicare capital payments would not fall below these costs.

Now, the handling of costs incurred is difficult, I know. Nevertheless, they must be handled in an adequate and reasonable manner. I have personally written to Secretary Sullivan with other concerns regarding these proposals.

Changes in the proposal, it seems to me, are necessary to ensure adequate and rational investment in patient care and to preserve the integrity of prospective payment for capital.

So, I want to support the inclusion of capital payments into the prospective payment system, but I want the rules to be fair and equitable, and that is the only request that I would find on this subject. But again, I would like to welcome you, and appreciate what you are trying to do out there and hope that we can work together in trying to get some of these problems resolved.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Hatch. Gail, just two quick questions, then a couple more that I will send you in writing. You have estimated that from 1988 to 1992 total capital costs will go to about 7.9 percent a year in order to update the 1988 base rate to the 1992 level. Given past rates of growth, this appears a bit low.

The American Hospital Association data suggests that it is closer to 9–10 percent. What were the assumptions that HCFA made in coming up with that figure, and is there any taking another look, so to speak, as you make the final rule?

Dr. WILENSKY. My answer to the first part of the question is that we will use the 1989 data, rather than the 1988 data, and that will give us a year's more recent data. And we will also attempt to project the future, which is, as always, difficult.

What we are redoing now with our newer data is using the actuaries' best estimate as to where we will be in 1992, with 1989 data, and some information about 1990. This will narrow the difference in the projections. But there will be some difference. We will go with our HCFA actuary's best estimate.

Senator ROCKEFELLER. In other words, you have moved up 1 year, but what were the assumptions that——

Dr. WILENSKY. I will have to provide them to you in writing.

[The information follows:]

CAPITAL ESTIMATES

In developing the proposed capital regulation, HCFA used a wide range of data, analyses and computer modeling. In order to facilitate general understanding and acceptance of the estimates used in the regulation, we have made information about our analytical activities available to ProPAC, CBO, and the hospital industry.

During the comment period, we met with staff of ProPAC, the American Hospital Association (AHA) and other groups to discuss the estimates used in the capital proposal. We made our data and the details of our modeling and other analyses available to them. A great deal of information has been released, especially to the AHA, which has asked for the most information. HCFA has made extraordinary efforts to inform all interested parties of the details of the proposed regulation and its possible effect on hospitals.

Two issues have been raised concerning the capital estimates included in the proposed rule. The first issue relates to the level of the Federal rate in the proposed rule, a concern first raised by ProPAC. Medicare PPS-5 data (fiscal year (FY) 1988) was used for the proposed regulation and updated to FY 1992 based on our estimate of the increase in Medicare inpatient capital cost per case. We will be revising our estimates for the final rule based on more recent data, including PPS-6 data and the most current projection of capital cost increases and Medicare inpatient utilization. The PPS-5 and -6 data, as well as the actuarial assumptions we made in estimating the FY 1992 costs in the proposed rule, are available upon request.

The second issue concerns the estimate of aggregate Medicare capital spending. The estimate from our actuarial capital acquisition model deviates significantly from the estimate developed by the AHA. To better understand the reasons for the differences, we have met with the technical staff from the AHA and ProPAC to explore the estimating methodologies used. We believe that this type of open exchange is helpful and we continue to encourage it.

Throughout the public comment period, HCFA undertook an extensive effort to explain the proposed rule and to solicit comments. We provided a computer disk to every hospital to facilitate each hospital's projection of its payments under the regulation for the entire ten-year transition period. Each member of Congress received an information package including a description of the proposal, a worksheet to calculate individual hospital payments, and a questionnaire to use in discussing the impact of the regulation with constituents. When the rule was published we provided detailed briefings for Members of Congress, the press, hospital and financial industry representatives, Congressional staff, and staff of Congressional agencies. Numerous other presentations and meetings were held with groups and individual hospitals during the comment period.

We look forward to continuing to work with all interested parties on matters related to Medicare payments for inpatient hospital capital costs.

Senator ROCKEFELLER. All right. West Virginia University built a new teaching hospital a few years ago. Their capital costs are about $1,700 per case, which is, I think, three times the national average. Will they be held harmless, in fact, totally harmless during the transition phase except for the current 10 percent discount included in last year's budget agreement. As importantly, they have a 30-year tax-exempt bond that they have to pay off and are naturally worried about that. What will their situation be after the 10-year transition? Is HCFA considering additional measures to help hospitals in situations like this?

Dr. WILENSKY. If they had completed the project as of 1990, they will be held harmless at 90 percent, as provided in the proposed rule. If they had not completed the construction, but are partway into the construction—I do not know what the answer to that is—it will depend on how the proposed rule differs from the final rule.

One of the issues that has been raised, that I was addressing with Senators Breaux and Daschle, is that the proposed rule is very strict in saying only those expenditures that were completed as of October of 1990 will be held harmless. We invited comments and, in fact, indicated that we would consider liberalizing that definition to include commitments that had not yet been completed, and those, even, that had not been clearly initiated, but somehow firmly committed.

What we are doing now, is looking at how that can be defined. Assuming that a capital project has been completed, or that will fall into the new definitions of obligated old capital, it will be protected at the "hold harmless" rate for 10 years. After the 10-year transition, the hospital will receive the Federal adjusted amount per case, as it exists as of that time. Our view is that hospitals have had more than a 10-year period because, after all, as of 1987, hospitals were put on very clear notice that prospective payment would be used to reimburse hospitals after 1991.

So, a period from 1987 to 2001 is clearly covered during which hospitals knew of the move to prospective payment. Some could say that since it was made clear in 1983 that this was the way we were going, hospitals really have known for a long time. But our view is that there is more than an adequate transition period to get from here to there in the new system.

Senator ROCKEFELLER. Fair enough. And I thank you, Dr. Wilensky, very much. Go ahead, Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Dr. Wilensky, I apologize for not being here for the balance of your testimony. I would just like to reaffirm your understanding and your sympathy for rural hospitals. I know that you already have, but I just want to underline it one more time.

As you well know, rural America is having a tough time. And when I say rural America, I mean not only Eastern rural America, I particularly mean Western rural America, which is much different than Eastern rural America. There is no comparison. Western rural America is a function of distance; great distances between communities.

I mean, for example, in my State of Montana, the distance from one end to the other is greater then the distance than from here to Boston. I mean, it is a long way to drive.

And many people in small communities in their home town, if they cannot get health care, have to drive very long distances. I am talking about 100–120 miles to see a doctor, to get basic health care. That can be a 2-hour drive. And that is assuming good weather, which obviously is not the case in the winter with blizzards and storms and whatnot.

So, it is critical that the smaller community hospitals are alive and well. And in another respect, often, in most cases, they are the largest employers. The hospitals in smaller communities—at least in my State—are the largest employers.

Now, it may be that rural America is declining for other reasons that are beyond our control here. But I do not want our policies here forcing rural hospitals to close or to downsize, to be the reason why people leave these smaller communities. Now, as I understand it, your proposed regulations have a national rate that does not discriminate against rural hospitals, is that correct?

Dr. WILENSKY. Correct.

Senator BAUCUS. And I also understand that sole community hospitals will be exempt from cuts in capital payments, is that correct?

Dr. WILENSKY. Under the proposed rule, they are not completely exempt from capital payments. They are eligible for an exceptions policy, but not one that would completely exempt them. It is an

issue that has been raised to us, and we are considering alternatives between the proposed rule and the final rule.

Senator BAUCUS. Yes. And frankly, I just think we ought to make it permanent. A small, sole community provider should be exempt from all this stuff because, as you well know, otherwise they are just so hassled, they are spending more time trying to stay alive than they are, in many respects, providing health care. I strongly urge you to consider that. As I understand it, too, you do include volume protections for small rural hospitals. Are there volume protections?

Dr. WILENSKY. No, there are not.

Senator BAUCUS. Do you think that is a good idea?

Dr. WILENSKY. I am not even sure that anybody has raised it to us.

Senator BAUCUS. Well, I am now.

Dr. WILENSKY. All right. That was an incorrect response. The answer is, it has been raised, and we are working on it.

Senator BAUCUS. I would like you to look at that again, if you could. I understand further that you propose eliminating the geographic wage index adjustment, is that correct?

Dr. WILENSKY. We are using a wage index adjustment. We have clearly indicated that we are not wedded to it philosophically, but at the moment, it is the best measure of variations in capital costs that we can come up with, and better than construction costs, which is our other option right now.

Senator BAUCUS. All right. I appreciate that. You well know the damage that PPS caused rural hospitals when it first came out I sense that you are recognizing some of those lessons in that the capital payment provisions are not going to fall in that same trap. And I just strongly urge you to not let that happen.

I might tell you that I took one of your predecessors—Dr. Bill Roper—to my State a few years ago. Put him in a small plane, a single engine plane. We flew from Billings, Montana up to Harlowton, looked at a hospital there, then over to Lewistown and to another community before going back to Billings. Fortunately, it was rotten weather. Bill Roper was white-knuckled as we loped over those hills dodging storms to get to these smaller communities, and I can tell you, it made a real impression on him.

Dr. WILENSKY. Well, I am supposed to be doing this with you in September. I hope I will have better weather. [Laughter.]

Senator BAUCUS. Well, we are going to do what we can to arrange to have not only bad weather, but a plane that is not in the world's best condition. [Laughter.]

Senator BAUCUS. [continuing]. Thank you very much.

Senator ROCKEFELLER. Thank you.

Senator BAUCUS. I will be there with you.

Senator ROCKEFELLER. And with that cheerful thought—Gail, thank you very, very much.

Dr. WILENSKY. You are very welcome.

Senator ROCKEFELLER. Dr. Stuart Altman is Chairman of the Prospective Payment Assessment Commission, and Stuart, even before you have your nameplate before you, let me just ask you a question that we discussed, I think, 2 years ago.

If you assume that we will spend $765 billion on health care, public and private, this year, last time I talked to you, you had said that the Pepper Commission's analysis that by the year 2000 it would be a trillion and a half dollars was wrong, and you were suggesting it would be closer to a trillion 8. Are you still in that ball park by the year 2000?

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, WASHINGTON, DC

Dr. ALTMAN. Yes, sir. There are now estimates that suggest it could approach $2 trillion, but I have trouble figuring out the difference.

Senator ROCKEFELLER. Yes.

Dr. ALTMAN. But it is very high. 1.5 is now the lowest estimate that we see, and 1.7 is now the kind of accepted mean. Yes, sir.

Senator ROCKEFELLER. Do you also agree—and I am out of order—but do you also agree with what I think is another very dramatic way of explaining the spiral that we are in is that if the average health benefit for the average employee in America today is $3,161, that if we continue in our present course, which is not doing very much, that that figure by 2000 will be $22,000 per employee just for health benefits?

Dr. ALTMAN. Well, I think it converts itself closer to that. I would have to go back and look at the numbers, but it is of a magnitude several times fold. I would have to look and see how really high it is; I do not know. But it is significantly higher than the $3,200, because not only does it double twice, but what happens is that it disproportionately is going to fall on the employed sector. So, you cannot just multiply in an even amount. So, it is going to be very large.

Senator ROCKEFELLER. I think finding ways to get people's attention on what is going on is——

Dr. ALTMAN. You and I share that, and I know so does Senator Durenberger. We have been around this a long time, and it is hard to believe the numbers that we are talking about, but they just keep going up.

Senator ROCKEFELLER. Yes. Now, as I said, I was out of order. We welcome you, and welcome your testimony.

Dr. ALTMAN. Well, thank you, Senator. I will try to be brief. Let me just tell you where we at ProPAC have come out. For those who have watched the ProPAC deliberations on this, it is no secret to know that while we did come up with a unanimous recommendation, there were some on the committee that were less than jumping for joy in including capital in the PPS system.

Nevertheless, it did seem to all of us, and to me in particular, that this was the right time to do it. As Senator Durenberger has said, we have been around on this a number of times, and that it makes sense for all the reasons that Gail articulated, as well as every member of the panel, the committee as well.

So, we do support the inclusion of capital in the PPS system. But there are some important issues that I want to bring to your attention, many of which have been discussed, but a few have not.

First, I think we have to recognize something that when you say it, is so self-evident. There is no such thing as capital funds. Once capital is included in PPS, the hospitals get money. And there is no difference between capital funds and operating funds; it is all one set of dollars to them.

And as you pointed out, Senator, most hospitals that are struggling wound up using their capital funds for operating expenses in the past, and will continue to do so in the future.

Now, the reason why we support the inclusion of capital in the PPS is because we have created a distortion in the incentive system by paying capital under a cost-based system, while the operating expenses are on a PPS system. So, that if you were going to include them—which we support—you also ought to recognize that you ought to develop a common set of adjustments. And those rules that Gail talked about are not common.

Let me just point up a few that were not mentioned, and I am sorry Senator Baucus walked out. For example, it is true that rural sole community hospitals and large urban disproportionate share hospitals could get an exception payment under less stringent criteria than other hospitals.

However, the proposed rules require that the only way they will get this special exception is if their Medicare profit-margins go to zero.

You, the Congress, the Senate and the House, have decided that there are certain classes of hospitals that should get exceptions for a variety of reasons, which I will be glad to discuss with you, that are not related directly to either the capital payment or the operating payment. They are directed to the survival of that hospital.

To subject those hospitals to a hoop to jump through that they not have positive margins on Medicare ignores the fact that they could have very strong negative margins for non-Medicare patients. Now, that is true for rural hospitals; it is also true for urban disproportionate share hospitals, and it is also true for teaching hospitals.

Therefore, if we recognize that what we are dealing with is combining Medicare funds for operating capital into one part of dollars which will go the hospitals, it seems to us that we ought to be developing a consistent set of standards, and the proposed rules, while it goes part of the way there, does not go all the way.

So, we would recommend, particularly, two changes. On the adjustments: rural sole community and disproportionate share hospitals, should not have to claim that they have no positive operating margins, they should just get the exceptions payments.

Two, very important in the future, the update factor. Over time, that update factor should become a common update factor. You should not have one update factor for operating and another update factor for the capital side because, remember, it is just dollars.

Yes, that update factor should be a combined weighted average, and it should start right away. There is one aspect of these proposals that, for the life of me, I just do not understand, and it is the update factor. I have gone around and around on it. The current proposal is that hospitals get an update factor in relationship to

capital expenditures of a year or two ago. That should not be the way it operates.

This becomes an operating variable that you have under your control. You should adjust it just the way you adjust the update factor for the operating side. And as I said, I believe—and the majority of the commission went along with me—that these ought to be combined. So, on those two areas, I think it is important that we maintain commonality.

As you have talked about many times, we believe that the exceptions process should be made permanent. There is just too much variability in capital.

While we support its inclusion and we are very pleased with the way the Secretary and Gail have operated to deal with a lot of the problems, you are never going to be able to deal with all the problems.

I understand what Gail is saying, you are going to have a 10-year transition, we can worry about it 10 years from now. I would like to see it put in law now, and not wait for 10 years because we will need that degree of assurance. We have also talked about the definition of "old" capital.

Now, that is particularly important in the near term, in the next 3 to 4 years, as sort of semi-old, semi-new capital comes on line.

Several of the other Senators talked about what the definition—how far along one has to have been in terms of investments before you consider it old capital. I think that discussion needs to be clarified, and I hope HCFA is quite liberal in their discussions.

Finally, my staff and Laura Dummit, who is our Deputy Executive Director for this area, has been working with the HCFA staff because there are some parts of their models that they use that are very critical for these rules that we do not understand.

Now, they have refused to share the complete model with us, but we have been very pleased by the amount of cooperation we have had in the last several months since they came out.

The AHA has developed their own models of hospital capital costs and have estimated capital payments that are about 10 percent different than what HCFA estimated. That is very troubling. We went through that when we introduced PPS in the first place, and it led to $2.5 billion of extra money flowing out during the first couple of years, and then being pulled out the third and fourth year. That is not a good way to do public policy. So, we are working with HCFA in trying to better understand those models. And if we come up with any differences, we will, of course, let you know.

Now, finally, as I am sure you know, we will be monitoring this closely as it proceeds through the process, and as it is implemented, and will be glad through time to come back before this committee and give you our sense of how well it is working.

But in conclusion, we do support the Secretary. We do think that Gail and HCFA have done a good job. But we would like to see the kind of changes that I have outlined. And, of course, I would hope that my complete testimony would be included in the record.

Senator ROCKEFELLER. Of course.

Dr. ALTMAN. Thank you.

[The prepared statement of Dr. Altman appears in the appendix.]

Senator ROCKEFELLER. I would call on Senator Durenberger for any questions he might have.

Senator DURENBERGER. Thank you. Stuart, thank you very much for your testimony. Also, you referred to it, the spirit of cooperation between the two of you really helps us to understand the problem, not only when you get to testify, but I am sure it makes a big difference on the regulations proposed. It has always been your style, it has always the Commission's, and it gets better all the time. I think all of us here appreciate that.

I asked Gail some questions about teaching, some of those kinds of issues. At the commission level, did you look at——

Dr. ALTMAN. Yes, sir.

Senator DURENBERGER.—different kinds of hospitals in that respect and come to the same conclusion she came to?

Dr. ALTMAN. Yes. Let me emphasize what I started to say before. We believe that there should be one common teaching adjustment, following the logic that there should not be a difference between capital and operating. We should include, if it is the law of the land—which it is—that there be a teaching adjustment, there should be a teaching adjustment for capital as well as for operating. Now, they used a very narrow definition of their model. And on the basis of that narrow definition of their model, they came up and showed that teaching hospitals did not require an adjustment.

But we have been around this issue for the last 4 years, and Congress has decided that regardless of the narrow definition of the model, there are other reasons why teaching hospitals should get an adjustment.

Well, if you should get it on the operating side, you should get it on the capital side, as well. We support the idea that teaching adjustments get an adjustment beyond what the narrow definition of the model suggests.

We have some differences on the level, and we believe that probably should come down a little bit. But it is the recommendation of the commission that there be an adjustment for teaching hospitals.

Senator DURENBERGER. Now, let me ask you a question I did not ask Gail. It was prompted because you talked about one pot and a consistent set of standards, and all that sort of thing. It strikes me that we are now going to have a truly prospective price for Medicare that incorporates operating and capital costs in it, and we are seeing increasing amounts of negotiated prospective pricing going on. My question relates to the accessibility that different hospitals have to capital.

What is the continuing rationale for the subsidy through 501(c)(3) tax status to contributions to capital? I can understand it—and I am not arguing it one way or another—if we are talking about a specific service and a specific situation.

But that is a fairly large subsidy more available to some hospitals than it is to others. Has the commission thought that out at all?

Dr. ALTMAN. I do not really think that issue has ever come up before us. So, as a commission, it has not. It is an issue I have thought about a little myself, but we have not discussed.

Senator DURENBERGER. Good. I just was curious as to whether or not you had in any way, because we obviously are going to live

with some disparities. If everyone can get their costs reimbursed, that is one thing. But the little hospitals do not have much. They do not have rich people to put their names on buildings, and stuff like that, as some of our more prosperous centers do. And that is the reason I ask the question.

I asked Gail another question that related to medical technology, and maybe this is an area that the commission has given a little thought to.

Dr. ALTMAN. Yes.

Senator DURENBERGER. In the old days when we first contemplated prospective payment for capital, we did not think about dividing physical structures from medical technology investments.

Dr. ALTMAN. Right.

Senator DURENBERGER. Do you see any reason for a Federal role in differentiating reimbursement for the acquisition of medical technology from the general way we have combined these payments into one payment system?

Dr. ALTMAN. Well, I guess I listened to Gail's answer, and I generally support it. First of all, no matter where you draw the line, it is so arbitrary. Where does technology end and equipment—we toyed around a long time on moveable and fixed, and we have seen the ingenuity of the American health care system rival that of the Pentagon any which way in terms of how its maneuvers, definitions of fixed and moveable. We have MRIs on rails that run around the country, attach themselves to hospitals, and then when you think they are fixed, they move them.

So, I finally was forced, as were others on our commission, to say forget it, it just will not work and, therefore, went along with the idea that you have to overcome that fixed and moveable really are the same. And I think you can draw the same distinction between technology and fixed structures. They just blur.

Senator DURENBERGER. All right. Thank you.

Senator ROCKEFELLER. Stuart, I am going to send you three questions in the mail. Right now I would like to ask you how you see the state of anxiety, concern, state of play of those in the private sector making health care decisions.

Dr. ALTMAN. Private sector——

Senator ROCKEFELLER. Well, let me go on.

Dr. ALTMAN. I am sorry.

Senator ROCKEFELLER. I am trying to resume my earlier conversation.

Dr. ALTMAN. Yes, sir.

Senator ROCKEFELLER. There appears to be a growing sense that the health care crisis is affecting people individually, and they are willing to say so.

Dr. ALTMAN. Yes.

Senator ROCKEFELLER. But when it comes to doing something about it, or accepting a push from Washington, for example, on public health policy matters, people simply grow reluctant.

That on the one hand, they do not like paying for other people's health care through higher health insurance premiums, but perhaps they do not understand that they are doing that because somehow that message is not getting through. They know they are

paying more than they want to be, but they have not made the correlation.

And one of the interesting things about $3,161 to $22,000, let us say, or $765 billion to $2 trillion is that it gets so large that one intellectually just walks away from it because it is beyond rational solution.

I mean, anything that is growing at that rate simply is not something that I, as a citizen, can deal with. I cannot deal with it intellectually, I certainly cannot solve it, so I walk away from it. The Dave Durenbergers and Jay Rockefellers do not share that view; we want to do something, and we are worried about it, and so are you. What are you hearing out there about the state of concern on the part of people who ought to be concerned, but perhaps, are not concerned? In other words, the people that Dave and I, and you turn to for reinforcement about the fact that there is something called a health care crisis, and just sort of take off on that.

Dr. ALTMAN. Well, thank you for the question. I have been, as you know, worrying about this and trying to deal with it for the past 20 years. There is a fundamental difference in the land today than 5 years ago, surely than 20 years ago.

Twenty years ago we were mainly concerned about the 15 million uninsured. The middle class felt comfortable, the business community did not really deal with it.

I am spending more time than any other dealing with two groups of people. One are the business community, which have reached a level of alarm that I have never seen before. That does not mean that they are able to come up with a unified front on what that solution looks like. They are as frustrated as the rest of us. But I do believe that you will see, within a very short period of time, a substantial number of the business community coming before you asking, demanding, begging for reform; that they cannot survive under the onslaught on what is coming down the pack. But what is more troubling to me is the group of middle class, young people in particular but not completely young people, who are finding themselves either frozen out of the insurance market, or having all kinds of exceptions put onto their policies because of some either real illness, or perceived illness.

Now, the nature of our land and the size of this problem is so enormous that that level of anxiety and concern has to rise to very high levels before it spills over and reaches you. And I would not use the lack of concerted effort as any indication that there is not this problem. It is very real out there.

Every survey that has been taken suggests that an overwhelming majority of the Americans badly, badly want a major reform in our system. And when all gets said and done, the reason is they are afraid. They are financially afraid. It is not that they dislike their doctor, or do not trust their hospital, it is that they are financially afraid. And every indication that you and I know is that this problem can only get worse. There is no self-correction out there.

And, as you know—and I know you care about this deeply—I would hope that we would try to solve that problem before it is so serious that there is only one solution, and that solution, if it gets that serious, will only be a take over by the Government, which I would not want to see.

So, I know you and I share the idea that we have a brief window of opportunity left to fix it. It is coming. I get examples every day of people who, 2 years ago, 5 years ago, would never be complaining.

Senator ROCKEFELLER. And Dave, interrupt me or prove what I am trying to say, Bob Blendon came before this committee some months ago——

Dr. ALTMAN. Right.

Senator ROCKEFELLER.—and somebody was questioning him. And he said, well, yes, it is a concern. I thought he was fairly flippant, myself. But he said it is a concern, but it really is not in the top three or four issues that Americans worry about. It is bubbling, but it is not going to be there. It is not something, for example, that is going to have to be addressed politically in 1992, or sometime in the future. Then I listen to you, you are saying you hear more and more from businessmen and the young middle class, et cetera.

Dr. ALTMAN. Right.

Senator ROCKEFELLER. But it still does not result in anything. And if you accept, as I do even agree with you, the premise that if something is not done within the next 8 or ten years that we will go to a single payor system.

What triggers this? What has to happen? And I am not asking this politically. I promise I am not. What do you see happening to accelerate the pressure on us in Washington so that we have to take action? Do you see this happening within the next 4 or 5 years, or do you think that we are going to have to legislate without public opinion backing us up because the whole thing is so complicated and impossible?

Dr. ALTMAN. Well, I left a conference this morning in New York, Bob was with me, on this issue. And we were trying to figure out what will happen, what will that mushroom look like when it hits, how high will that cloud look? And my sense is that this is the issue. The issue is that for every dollar increase in expense that is hitting, because of the fact that there are 3 payors, there is the Government, then the individual, and the business, or private insurance.

And given the fact that the State Governments cannot afford dollar for dollar, and they are now paying 60 cents on the dollar when it comes to hospital care, and some States as low as 20 cents on the dollar for physician services.

And now, through the DRG system, we at the Federal level have figured out a way—while I am sure we are paying just about right, I know—some hospitals feel we are only paying 95 cents or 90 cents on the dollar—that means that every time a dollar hits, $1.20, $1.30, $1.40 goes onto the business side. And they now know it.

They are going through a transition period when many of them think they can control it by some kind of managed care, and something like that. But more and more of them realize the only way they can control it is by reducing their benefits, eliminating coverage, or dropping some family members.

Now, if that is going to happen—which I believe it will happen—the number of uninsured will grow from 37 million to 50 million just like that, which will accelerate the cost shifting, and it will go

over to $1.50. And what you are going to wind up with is the 20 people who were left insured will be picking up the whole system.

Now, it will accelerate because of the burden. Now, if it was not for the ERISA rules and a few other limitations on the ability of business to drop coverage, I think you would be seeing it already. And I do not know when it will happen. I would have thought it would have happened 5 or 10 years ago, so I do not want to predict what month or what year.

But I do see the number of uninsured growing substantially, which will put an added burden on the business community and the individual unless the government, you, are prepared to sort of pay not only your share, but a greater share on Medicare and Medicaid. And I must admit, I do not see that happening. I surely do not see that happening at the State level; they do not have any money. And it is hard to believe that it will happen here.

Senator ROCKEFELLER. Let me just add one thing, and, again, David, interrupt me. I apologize to the audience, those who were here to hear about hospital capital may not be pleased with this diversion.

But I was absolutely stunned several weeks ago when the New York Times, having combed the world of health care and rejected all kinds of solutions which might have had some appeal to Dave, and myself, and yourself, and then in this very kind of final way, the solution came down to managed competition; that is the answer.

I think it is fairly clear to most of us that managed care saves some money up front, and then stops doing so. It is certainly a wonderful thing to do. Southern California Edison testified before the Finance Committee about their managed care programs this past spring. They said their managed care program was working, but their health care costs will still double every 6 years. They favor expenditure targets.

I wrote the New York Times an absolutely brilliant letter refuting it, which they refused to print. Actually, that is probably what bothered me more than anything. But when the New York Times, with all that brainpower, comes out with that kind of a solution, it is scary.

Dr. ALTMAN. Well, I must admit I came away with the same feeling to the point where I thought the editors did not read their own newspaper, because if they read the columns, they could not have come up with the editorial that they did. I agree with you completely.

Managed care has an important place in our delivery system, but if anybody thinks that it alone can stem the flow of this $1.7 trillion monster coming down, they are sadly mistaken. And I was surprised. I had to believe that the editors are quite different than the people that wrote the article.

Senator ROCKEFELLER. Will you write them a letter?

Dr. ALTMAN. You think my letter would get—but yours did not? I would gladly write them a letter.

Senator DURENBERGER. He did not sign his. [Laughter.]

Yes. Just maybe an observation, and not by way of suggesting an answer to Jay's question, though I love to hear the question and I love to hear the response. But as long as I was being retrospective

on capital, this is my 13th year sitting on a committee believing that somehow we could improve access in this country by reducing costs by changing the payment system. Like a lot of other people, it took me a long time. But I have come to the conclusion that if that is all we do in this committee, and over on Labor and Human Resources, is sit and listen to all the people in pain and wring our hands about the fact that we are running out of categorical names for categorical programs to meet all their need, we can never solve our problems.

And I guess in partial response to Jay's question, I would love to see the people who have been spending a lot of time trying to change the system by changing the financing start bringing in the system itself and talking to it.

One of the tentative conclusions I have come to is that probably 10 percent of the doctors in this country are efficient and save us a lot of money. And we sit here and penalize the hell out of them. Then there are 80 percent that would like to be efficient, but do not know how. And then there are 10 percent who are ripping us off. But the problem is the 90 percent and the way we practice medicine in America.

And I am lucky enough to have, in the State that I represent, the lowest paid doctors and some of the highest quality medicine in the country. By all of the measures we are going to look at in RBRVS, northern Minnesota is on the bottom, southern Minnesota is second from the bottom.

We get an offer from Gail to do a 3-area payment system, and the doctors get together and say, no, we want one. And the guys in the high priced area say we will take the lower price just to help out. That is the kind of people I represent.

I can go to the Mayo Clinic any day of the week and find out why they will not buy a PET when all the rest of the competition has; why they will not buy a $4 million gamma knife when everybody else is out there buying them to make business for themselves.

And I do not want to get too far into the subject, but part of the solution to this problem is going to be to go beyond our capacity, and start dealing, as we are beginning to, with outcomes and guidelines, and so forth. But if we cannot find a way to encourage the delivery system in this country to change dramatically, all of this budgeting and all of this pricing is not going to accomplish it. Of course, then the alternatives will be a single payor system, or something like that.

Dr. ALTMAN. Well, I guess I would just say not to lose hope.

Senator DURENBERGER. We have done that, or I would not be here.

Dr. ALTMAN. The issue, though, is that you, at most, only control 30 percent of the hospitals and 20–25 percent of the physicians. And we have never seen a real attempt to change the financing system with some degree of uniformity, which every other country in the world has done.

So, what we have is not unexpectedly, one spigot sort of tightens up, or shuts off, or changes incentives, and the provider community does not like it, it runs to another spigot. And while I do not want to see one spigot, I do believe that the spigots ought to work in

some common unison, so that if we have a private sector and a public sector and an individual sector—right now we play one against the other.

Senator DURENBERGER. But it is a real struggle to take on, and the people in this committee struggled a long time to add preventive benefits to Medicare, the first ever, so we get mammograms.

And we sat around here, and some of the women staffers went off and got prices, and we come up with a $55 mammogram.

And a couple of weeks ago, I am in the Labor and Human Resources listening to Jill Eikenberry tell me that $55 is not enough, because in Los Angeles it is $180, and in New York, it is $290. Baloney. It is about $36.

But as soon as somebody on this committee decides they are going to do some good for somebody and put a third party payment system in place, there is somebody out there that figures out a way to take advantage of it.

I am exaggerating the point from a series of recent experiences in front of people on committees. But, this is the hard thing for the politician to deal with, and it is part of Jay's frustration.

Dr. ALTMAN. Well, I would just say in final I hope you will not let your frustration prevent you from continuing to try, because if it does not come here, I do not know where it is going to come from. It is really not going to come out there.

Senator ROCKEFELLER. This is just a half hour frustration break. Stuart, thank you very, very much. Very much.

Dr. ALTMAN. Thank you.

Senator ROCKEFELLER. Michael Bromberg, Federation of American Health Systems; Jack Owen, American Hospital Association; and Judith Smith, president and chief executive officer, Daughters of Charity Health Services of Austin, TX; representing the Catholic Health Association.

Jack, we will start with you.

STATEMENT OF JACK W. OWEN, INTERIM PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. OWEN. Thank you, Mr. Chairman. I am Jack Owen. I am the acting president of the American Hospital Association, and I find it a pleasure to be here today and see my old friend, Senator Durenberger, who started working on this in 1983, I think.

And so, what I would like is to just make a few comments. You have my written testimony, but I would like to just make some short comments about it. This has been discussed a great deal, and as you have heard, we have had an opportunity to look at the original proposed regulations and we would be anxious to see what the final ones are like, and we might have a lot more to say at that point.

But let me just quickly say that since 1983, there has been an attempt to develop a fair and equitable way to include capital in prospective pricing.

And the problem we ran into, very honestly, was that every hospital was at a different place in the capital structure during the period of time that this was taking place and, therefore, it made a

lot of sense to pass through on a cost basis the capital that they needed during this period of time.

The problem with that was that it was unfair to some hospitals, especially hospitals who did not have a capital problem, and that they felt the only way they could get capital was to go out and borrow money.

This did not make any sense, and if you believe in the theory of pricing and what we have been talking about, then capital would be included and management would make a decision how and what is the best way, in each local community, to move this capital around.

The problem, of course, is how to move from one kind of system, a pass-through, to another with the least amount of disruption, and that is what we are most concerned about.

Dr. Gail Wilensky's staff, I think, has done an admirable job of attempting to level this playing field. She has tackled many of the problems we have raised, both to HHS and the Congress, over those past 8 years that Dave Durenberger was talking about.

I have to say that we have had ample opportunity to comment, and have done so, with Gail, and we hope that the comments that you see in our written prepared text will be taken up by Gail. We are concerned over the assumptions that Stu just brought up, because there is quite a bit of difference in these assumptions. And in the long run, it is going to create some problems if these assumptions are incorrect.

However, I might say that I am not here today to embrace the regulations as originally proposed, because they do fall short in several areas. What I hope is that these hearings will convince Dr. Wilensky to amend the regulations, to move toward the needed steps so that we get the kind of equity that we want, and you have heard about around this table today.

One of the most important concerns that we had at the very beginning of this was the definition of capital and to be consistent when we try to determine what is "old" capital.

And we have to look at those items which were included in capital costs at the time that the hospital obtained this capital; the leases and the taxes; the obligated capital. And those definitions which we have lived with under Medicare, and when most hospitals borrowed money with the assumption that they would be paid in some fashion. Now, if these are included in the revised regulations, we have gone a long way, I think, to alleviate the concerns of hospitals. But if not, we have got a problem.

And along with that, we need a date for commitment—you heard about that, and I will not go into that any deeper—a date of when old capital was really committed, that needs to be much closer to the time the regulations go into effect than what is currently proposed. And that is the hold harmless side of it.

Secondly, we need to be assured that capital payments will be updated annually and that the system is not just a ruse to eliminate capital payments altogether.

And I think Stu mentioned briefly here about tying the two together and what that means. And there is, of course, some concern by hospitals as to whether a proper update will continue which will allow not only adequate operating monies, but capital as well.

Because of the history of the Federal Government not living up to its promises in health care payments, there is a great concern among our members that even a fair system, once it is started, will it continue, or will budget deficits and other factors cause the administration or Congress to cut back from principles that we agree on today.

Therefore, we would like to see a safety net, or floor, or something like that established at some percentage of actual hospital costs that is there for some period of time. This perception that the government is not going to follow through is just rampant out there in the members' minds.

Now, I have a great deal of faith that Gail will make some of the necessary changes. I think she has listened very carefully to us, and I think she has listened to other groups, as you are going to hear. But if not, I hope we can count on this committee to help hospitals if we have to go through legislation.

With that, and with the preparation of the material that I have sent in to the committee, I would stop and see if there are any questions later on. Thank you.

[The prepared statement of Mr. Owen appears in the appendix.]

Senator ROCKEFELLER. Thank you, Jack. Mike.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HEALTH CARE SYSTEMS, WASHINGTON, DC

Mr. BROMBERG. Mr. Chairman, thank you for this opportunity to be here on behalf of the investor-owned hospitals of the country. I am going to try to be brief. I am even hoping there is enough time left over at the end to talk about the New York Times editorial one more time. But let me briefly say this.

This is one of those rare occasions, I think, where an industry comes before you, having looked at a regulation which it feels is absolutely unnecessary and yet, Dr. Wilensky and her staff have done such a politically astute and marvelous job of trying to do it, that I think we are close to something that we all can say is, at least, livable for awhile.

And we therefore are limiting ourselves today to some suggestions to improve it, rather than go through the litany of why we think it is unnecessary. Jack has covered them; they have been covered all day. We have heard that they are going to be corrected, we hope. So, I would just like to focus in on really one or two.

We represent an industry that shows that about 10 percent of all of our capital costs of all the investor-owned hospitals in the country are property taxes. They are presently reimbursed on a cost basis. They have nothing to do with efficiency, management, prudency, or anything else. They are imposed on us by local government.

And therefore, we think it is not only important to do what Gail apparently is going to do, which is include them in the definition of old capital, but we think it is important, just like it is to look at disproportionate share, teaching, and other adjustments, to figure out a way that we should not take that 10 percent of our capital

and throw it into a pot and lose it, because it is a cost we are going to have to pay and we have no control over it.

I think leases are another example. More and more hospitals are using them as a financing mechanism, which is good. They should certainly be recognized, and that will make the "hold harmless" more important.

I want to address myself basically for the rest of this short time to the idea of a payment floor, and to some of the comments I heard this morning on why it may or may not be a good idea.

First, let me say Dr. Wilensky's reaction to it was she did not like it because it smacked of cost reimbursement, which we are trying to get away from. Well, so does the 10-year transition and a lot of other things, that is why we do them; to buffer harm during a period, or forever, as a matter of fact.

Senator Durenberger had a proposal many years ago for a 7-year transition, which was a lot better than this 10-year transition, for a very important reason. Senator Durenberger's bill was what we call a rolling base.

It basically said that hospitals will get some percentage of their payment based on a prospective rate, and some percentage based on their actual cost that year.

This 10-year transition in this regulation says that the hospital-specific portion is based on a base year cost of 1988, 1989, whatever the year is, and that what happens during the next 10 years is irrelevant. That is a very important point, and that is one of the reasons we think that we very much need a "hold harmless."

Other reasons are we cannot predict what is going to happen with this regulation, we have not seen the model, we have no idea what the payment update is going to be, what OMB will recommend, what HHS will say, it is not in the regulation. So you cannot predict beyond a few years what is going to happen. I think this regulation will probably be livable for a few years, and I know the reaction will be come back to us when it is not.

But hospitals could fall off a cliff in years 4, 5, and six if there is no floor in there for that reason. The budget-neutral adjustments are unpredictable. And for all these reasons of unpredictability, and one last one I want to talk about, we think a payment floor is a good idea. The last one is geographic shifts of money.

Senator ROCKEFELLER. Permanent?

Mr. BROMBERG. I would think so, although I hope to be retired in ten years, so I am not going to fight the issue of whether it is ten years versus permanent. Much more important that it be done for the middle years of this regulation.

The geographic argument, I want to make it because no one else has made it, and I think it is important. I do not believe this regulation is going to change behavior. I do not think there is a hospital in America that is going to decide whether or not to undertake a capital obligation because Medicare has changed 2 or 3 percent of its income from one system to another.

But what I do think is that this regulation is going to shift a lot of money from one part of the country to the other, from one State to another, from urban hospitals to rural hospitals. Some of that may be good, some of that may be bad, some of it is unknown, and there is no rationale for it.

For example, I believe that the State of Texas and many other States in the Southwest, some in the Southeast, and some in the West are going to find continuously that they are getting less and less of their percentage of the capital spending for Medicare and more and more of it is going to go to Massachusetts, and New England, and the Northeast, and some other places.

And rather than sit here and try to figure out why or whether, I think a floor would give Congress a chance to monitor that to make sure that there are not severe impacts that were not intended, and to look at why they are happening before the ten years are up, or after the ten years, either way. But I think that more than just simple oversight is going to be required because of those facts. Some people will say they are based on occupancy; they are not. We have data that shows that some of the lowest occupancy States in the country, like Texas, have much lower costs and lower rates of increase than the highest occupancy States in the country, like Massachusetts. There has got to be a reason for some of this shifting, and I think it would give Congress a chance to look at it.

I might say that HCFA picking a 10-year transition admitted that there should be some relation to costs, and this is just another example of how we can buffer that hardship by having a floor.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Bromberg appears in the appendix.]

Senator DURENBERGER. You are welcome. [Laughter.]

Ms. Smith, are you next?

STATEMENT OF JUDITH P. SMITH, PRESIDENT AND CHIEF EXECUTIVE OFFICER, DAUGHTERS OF CHARITY HEALTH SERVICES OF AUSTIN, AUSTIN, TX, REPRESENTING THE CATHOLIC HEALTH ASSOCIATION

Ms. SMITH. Yes. Thank you, Senator Durenberger. I am Judy Smith, the President of Seton Medical Center and the Daughters of Charity Health Services of Austin.

I have two purposes in spending time with you this afternoon. The first is to show you what happens to a real hospital under all of these assumptions, and secondly, what can be done about the significant adverse impact of these proposed regulations for Medicare capital. I am one of the casualties to which you referred earlier, Senator Durenberger.

Seton is a 503 bed acute med-surg hospital serving Austin and the ten counties of central Texas, which are predominantly rural areas. They have a large Medicare population. About 44 percent of our services are to the Medicare population, so we are very much the focus of this kind of regulation and debate. This regulation is a disaster for us because of where it hits us in our capital cycle. We are a busy hospital. We have an 88 percent occupancy of our med-surg services. We are in a community which does not have too great a capacity. In fact, we have serious needs.

We are, in trying to respond to those needs, trying to create additional capacity in our facility for critical care, cardiac services through the Seton Central Texas Heart Institute, and the revamping of our over 20-year-old facility to accommodate the changes in

technology to move toward shorter stays for diagnostic and therapeutic services. What happens is that we get penalized for meeting these needs, and we get penalized severely.

If you look at Exhibit 1, you see under 3 different HCFA scenarios differing things. All of them are money losing scenarios. Under the best case, we lose $34 million during the 10-year transition under these capital regulations. That goes up to $40 million under the more realistic scenarios. I would submit to you that this is a solution in search of a problem, rather than the reverse.

If you look at the second exhibit, you will see that the rate of increase in capital costs for Medicare hospital expenditures is going down dramatically, and has been.

In addition, in the next exhibit, you can see that what we are paid under the prospective payment system has been a steady decline. Since $9 out of every $10 under Medicare are under the prospective payment system where the average hospital is losing money on every Medicare patient walking through the door, I can guarantee you that my board and I think very hard and long about how we spend that tenth dollar, the capital dollar; it is not a frivolous decision.

What we need in order to make these regulations work is first a workable exceptions process. And I would say to you that the exceptions process does not work. Seton, under that process, is eligible for a million dollars a year in exceptions payments under the latter years of this proposal. Yet, we still lose $4 million a year in capital. The process does not work.

Second, we need a safety net to protect us and other hospital caught at the wrong point in our capital cycle, but the right point in trying to meet community needs. And an 80 percent floor would provide that equity and safety net for Medicare beneficiaries. We also need to improve the predictability of the process.

If you will look at my last exhibit, you will see three different scenarios. The first line, what we call the "blue sky line" is what HCFA promised us in their model, something none of us have ever seen before in terms of reimbursement rates for capital, or anything else.

The green line, which gets a little closer to green grass and reality is, in fact, what happens if you take the assumptions in the initial 3 years of their model and extend them; a little closer to reality.

The red line, or red ink line is more likely what will really happen, and that is, if you take historically what has happened with reimbursement in the capital market basket. All of them are losing lines.

The unpredictability of which of those lines might, in fact, be the real one, combined with an unworkable exceptions process means that I cannot go to my banker, or to the bond market, to finance the absolutely essential capital improvements for the growing population of central Texas. It also means that I have a brand-new hospital opening this September to serve a growing area of the community that has no hospital services, and I have no idea how I will be reimbursed for those services for capital.

I think it is important, since we have been talking about this for so long, that Congress take the time to get it right; to have a work-

able exceptions process with a floor, and to put HCFA's money where its mouth is and say, if you are going to promise us the kind of updates in your model that you asked us to rely upon, that you, in fact, put them in the regulations.

I would be very happy to answer any questions you have, Senator, about the real impact of these regulations. Thank you.

[The prepared statement of Ms. Smith appears in the appendix.]

Senator DURENBERGER. Thank you very much. Maybe one or all of you will explain the floor concept. I think you were all here when I raised the issue with Gail, and you heard her response.

Are we talking about a temporary floor, or are we talking about a permanent floor below which nobody will ever fall so that they can count on it 25 years from now, or is this a transitional problem, and what is the design structure of this floor. Mike?

Mr. BROMBERG. Senator, I really cannot answer that question. I mean, we are talking about a permanent floor, clearly.

Senator DURENBERGER. You cannot answer it, or you can answer it?

Mr. BROMBERG. We all agree on it. But I think the issue is why, and if it is going to be ten years instead of permanent, that is better than not being permanent. The real question is why. And I used before the example of your bill when I testified before, so let me repeat myself.

The difference between your 7-year transition bill of several years ago and HCFA's 10-year transition is that yours was better for the industry. The reason is that your 7-year transition bill had a transition which built in over the period some reflection of actual costs, whatever they might be in those years.

The HCFA bill is a 10-year transition which builds in a reflection of costs in only a base year. A tremendous difference. Tremendous difference. That is one. There were a lot of other reasons, such as unpredictability—Judy is absolutely right—because we have no idea what is going to happen in the future in terms of what the updates are going to be; we do not know. We have no idea what the model HCFA used is; they have not shown it to us; we do not know what the assumptions are; we do know what the budget-neutral adjustment is going to be. There is no one that can predict that. And so, for predictability purposes as well, I think a floor would be very, very important so that Congress could monitor it.

And there was one last example I used, which is geographic shifts of money, which are unknown at this point in time, but which I think we can predict fairly safely. And that is we believe that this regulation over time is going to take a capital pot of money and primarily shift it.

It is not going to change behavior that much, we do not think. It is going to shift a lot of money from the Southwest to the Northeast. We are not sure why. We are not sure what the rationale is.

It is also going to shift a lot of money from urban hospitals to rural hospitals, which some on this committee may think is good and may like that part. But at least the geographic shift among the States is something I would like someone to analyze, and a payment floor would give you a chance not to have just your normal oversight powers, but to really analyze what is going on before

someone gets hurt very badly and falls off a cliff 4 or 5 years from now.

Mr. OWEN. You recall that you had a rolling base in your bill.

Senator DURENBERGER. Right.

Ms. SMITH. Senator, unlike my two colleagues, I do plan to be in this field in 10 years, and I am very concerned about what happens. [Laughter.]

I believe it needs to be determined——

Senator DURENBERGER. Did they make statements before I got here?

Ms. SMITH. Yes, they did. They talked about being short-timers. [Laughter.]

I am very concerned. I believe we need a permanent process. The technological explosion in health care is not going to be a ten-year process, it is a permanent process, as it is with all of the other high technology areas of our society and our environment. So our needs are going to continue.

In addition, we face the aging of the baby-boomers, and that is going to be coming in the 2020 timeframe. So, if we stop our investments at the end of ten years and go toward a much more serious form of rationing of capital expenditures in the face of the technology and population needs, I fear we will be in serious trouble when the baby-boomer group hits Medicare age.

Mr. OWEN. Well, can I comment just one second more on that? There is one real basic problem in the whole thing, and that is whatever system you have, the payment system is not fair.

Because even if we continue the pass-through and you dropped it from 85, to 80, to 75, to 60, hospitals are not going to make out any better than they are in switching. So, it seems to me that the real concern is what is going to happen down the road.

But personally, I do not have a problem of moving it into the prospective system; I think it makes some sense. But we have got to have some kind of guarantee that there is a safety net, or that the system will not just drop away once we get into there the way it has been dropping away right now.

Senator DURENBERGER. Maybe I will ask Ms. Smith the question in terms of the capital investment process—and again, I do not know the Austin situation, nor do I know specifically Seton Medical Center situation—but I can appreciate the Southwest-Northeast shift, or whatever you might call it. It is clearly the Medicare population is moving after retirement age, and that is putting demands on certain regions of the country that are not present in other parts of the country.

But my observation is that in all areas of the country, the first instinct of a hospital when it is put under pressure is survival, and I am talking about economic instinct.

There are plenty of other instincts that are more appropriate to cite than that, but when under some economic pressure, one of the first and major instincts is survival.

So, a fair amount of capital investment in areas where a hospital is not a sole provider of some kind is to meet competition and to meet that competition in a wide variety of ways. Sometimes it is technology investment, sometimes it is other kinds of improvements.

I wonder if you could just give us sort of an example of the capital investment process at Austin, how the process works, how much of a long-range process it is, as opposed to a less formalized process.

Ms. SMITH. All right. It is clearly a long range process. I can tell you that my institution is just completing a strategic plan to take us through the year 2000, in which we have looked very carefully at what is happening with medical technology and changes in medical practice, and the dramatic move to non in-patient forms of care.

We have involved our physicians extensively in that process, so we can really be on top of what is happening in those trends in medical practice. It is really not a medical "arms race" and I know that is a charge frequently leveled at hospitals.

I think it is misunderstood, in many cases, because what is the driving force is that the state-of-the-art of the way medicine is practiced is what is driving the need for that technology in terms of physician and patient expectations for what is available for their care.

I would also say to you that trying to constrain capital on the hospital side, as Stuart Altman so well pointed out, is just squeezing one end of the balloon, and it is going to pop out on the other side, as we found out so well in the certificate of need and health planning times. And that is that there are very strong incentives if the equipment is needed for it to be provided somehow.

And I can guarantee you that physicians and private entrepreneurs are looking extensively at how they can bring capital into the community, particularly to supplement declining physician incomes. The equipment will be bought if it is necessary to provide care.

Now, the question is, do you take it out of the hands of the larger organizations which can use it more effectively across a broader spectrum of patients and let it multiply in many small sites across the community?

Senator DURENBERGER. And obviously, I am asking for the impossible, which is the definition of necessary. And in this day and age I think that is pretty difficult. Just in my observation, for example, just confined to my own part of the country, that a small group of super surgical specialists can leverage any hospital in a competitive environment.

And the notion that they can barter their services between two hospitals, depending on which one makes the most substantial investment on their behalf, is the bane of a lot of hospital administrators, that I know. In the larger rural communities, at least in our part of the country, where major diagnostic investments are being made across the street from each other to respond to competition, certainly it is going to be characterized as need.

And I suspect that this whole structure is not the place to deal with that issue, and I am sure I came to that conclusion a long time ago. But in order to play a safety net, or to play something else, there is, at least, a question in this person's mind about the appropriate definition of necessity.

Ms. SMITH. Let me give you an example of some of the collaboration among the hospitals in my community. We have a partnership

with the city hospital and with a major group practice of physicians to bring an MRI to the community so that we can share it and not each buy one.

Since that time, there are entrepreneurs who have come into the community and solicited independent physician investments and private MRIs in competition with that. So what had started as collaboration among hospitals to try to provide an important service to the community and limit the proliferation, has been totally sidestepped by a hole in the system, if you will. There is collaboration in a number of other areas. We have agreed to support one trauma center in our community; we have agreed to support one children's hospital; we have agreed to support limited in-patient rehab services.

There are a number of areas like that where we understand that our community is not big enough that we should be splitting up key technology. There is one heart transplant center, that is in my institution, the Central Texas Heart Institute. There is one regional perinatal program.

We have tried and have worked on those thing on a voluntary basis. But we cannot do it when the barn door is wide open to be picked off in the non-hospital sector when those technologies could more appropriately be shared between a variety of patients within the larger institutions.

Senator DURENBERGER. Mike, I will recognize you in a minute. I just want to express my appreciation to the Association for asking you to come up here today, because I am surprised you have not been visited by the FTC, the Department of Justice, and a variety of other people for——

Ms. SMITH. For collaborating.

Senator DURENBERGER. Yes. For getting together and trying to do something reasonable for the people in Austin, TX. And I am also glad——

Ms. SMITH. Well, I will not tell if you will not tell, and I am sure Senator Bentsen will be on our side.

Senator DURENBERGER. I am glad I kept the questions going until Senator Bentsen got here. [Laughter.]

That is all the questions I have.

The CHAIRMAN. Well, I like the answers. That is good enough.

Senator DURENBERGER. I just told her she was a terrific witness.

Senator ROCKEFELLER. Which I missed altogether. Senator Bentsen, do you have any questions?

The CHAIRMAN. No. I came over here to get educated. I missed part of it already, I can see that.

Senator ROCKEFELLER. Let me ask a couple of things. You have all testified that capital expenditures are not, in fact, out of control, and that capital spending has decreased substantially over the past years, particularly in comparison to the early 1980's. Yet, capital spending is still at a level of about 10 percent a year, more than double inflation.

In addition, ProPAC's testified that the prices hospitals have faced in making capital expenditures have increased less than 2 percent a year since 1987.

ProPAC concluded that a large portion of the capital cost increase is due to purchasing more or more expensive capital. Is a

rate of growth for capital that is double the inflation rate sustainable?

Mr. OWEN. Well, maybe I can start out by saying I am not sure that that follows, because if the price changes, you could have a larger increase from the year before for a piece of equipment that would not be doubling or going beyond what might be considered unneeded capital.

I think that is a difficult way to try and come to a conclusion whether the capital was necessary or not by looking at whether the inflation rate was needed. There is no question in my mind that watching what has happened since the DRG system has gone into effect that it has had a decided slow down on the growth of capital, certainly, fixed capital beds and facilities. There will continue always to be an upgrading of facilities when you look at some of our older institutions on the East coast, as you know, Senator Rockefeller.

In New York, and New Jersey, and places like that there is a great need for updating laboratories and updating X-ray ancillary services. And the cost of upgrading those far exceeds what a hospital could normally have depreciated that for. The replacement cost tripled, quadrupled since 20 years ago.

So, just to look at the increase in inflation as being unconscionable, I would find that very difficult to accept unless I saw that the same thing was making this occur and it was unneeded facilities. Mike.

Mr. BROMBERG. Mr. Chairman, I think one of the points I would like to make is that I do not think this regulation will do anything to change that behavior, whether that behavior is good, bad, or whether those numbers are right or wrong.

And the reason I say that is I think most hospitals when they sit down to make a capital decision—should we or should we not spend $10 million or $1 million on this or that—do not look at the Medicare capital reimbursement line on their cost report.

Senator ROCKEFELLER. That is the point you made in your testimony.

Mr. BROMBERG. Right. Nor does the bank that loans them the money. They look at their total revenues, their total expenses, and their surplus.

So, I do not think that this regulation is going to really achieve that. I think what this regulation is going to achieve—and it has been carefully drafted to the point where it is almost livable, so we are not here to really blast it—but all it is going to really achieve is to shift money around.

It is going to take a pot of money and redistribute it. And for the life of me, I have seen no rationale as to why it is being redistributed. A lot more money is going to go to rurals, less to urbans.

As I said before, Senator Bentsen's State, I believe, Texas is going to lose money over the next ten years on this bill, and Massachusetts is going to grab it, or New York, or New England, or someone is going to get it. Because the data we show here shows that basically when you look at the capital costs per case, Texas is way below the average, so is their occupancy, which I find very interesting. They have lower occupancy and lower capital. And when

this National rate gets redistributed, I think it is going to go the other way.

So when they go to the national rate, I think the money is going to start being redistributed in a way that this committee needs to have strong oversight powers over, and that is the reason we have recommended you take the regulation, let it go through with the changes that I think we all think are going to be made, but add a payment floor to it, a safety net, to protect some hospital from going off a cliff 3 or 4 years from now so that you can have better oversight power. That is our only point.

Senator ROCKEFELLER. Did you want to say something?

Mr. BROMBERG. Just one quick point.

Senator ROCKEFELLER. Yes.

Mr. BROMBERG. If you really want to get at the problem that you want to get at, which is if you believe we are spending too much money on health costs and too much money on capital, and too much money in this system, I would really urge you to read that New York Times editorial again. Because the way to get at it is not through a capital regulation, whether we can live with it or not, or whether we fix it or not, or tinkering here and there. The way to get at it is to get at the demand side of this equation through changing the tax law and encouraging managed care.

And I really think that New York Times editorial did not just talk about managed care, it talked about a significant reform of the tax code to redistribute the money from rich people to poor people, and some incentives and to control costs through things like managed care.

But I really do not think this regulation is relevant to some of the concerns you obviously have and which we share.

Ms. SMITH. I wanted to make two comments about it. One is a point that I had made earlier, that when $9 out of the $10 for Medicare patients are already seriously constrained on the operating side because we lose money on every patient who comes in, we think long and hard before we spend the 10th dollar about whether we can support it, and whether it is justified. So, I think that is one important point.

A second one is that we are talking qualitatively different medicine in purchasing that technology, and we are talking about doing very different things with it. It is not comparing apples and oranges.

Let me give you just a couple of examples. One major expenditure for hospitals right now, and an explosive one, is in various microsurgery things that will allow us to do surgery through laparoscopes, which are making incisions about a half an inch in the abdomen, or in the knee, in the case of arthroscopes.

We are doing microscopic surgery, which allows us to operate on a person for gallbladder surgery or knee repair surgery in those two examples, and they can go home within 24 to 48 hours, instead of staying in the hospital five to seven days. They have a recovery that is measured in a week or two instead of a month or more in terms of their ability to function again in society.

So, by purchasing that technology, we have reduced the costs of health care dramatically and reduced the morbidity and the cost to that individual in their functioning in their job and in society. I

think those are valid capital expenditures. They are expenditures that did not exist several years ago. It is a new thing that we are doing, and one that I do not think that any of us would argue should not be done, and we should go back to the old ways of practicing which were very hard on folks, to be real honest.

Senator ROCKEFELLER. That leads me to a thought, you used the word "we make the decision to buy a certain piece of new technology equipment." I have been told, in fact, that is not a decision that administrators make generally in hospitals, it is a decision that doctors make.

And that is a very important question, and I would like, in fact, for each of you to address that. How is a decision made in a hospital if somebody wants MRI, or whatever it might be? Who makes the decision? How are those decisions made? Is it the physicians or the administrators?

Ms. SMITH. Let me talk to you a little bit about that, because Senator Durenberger mentioned earlier the problem of the overly influential group of high-cost surgeons. What we do, and what many more hospitals are also doing now, is we have a technology assessment committee composed of all the specialties on the medical staff, and we give them a fixed dollar amount and say this is what we can afford to spend for next year's capital budget; you fight it out and tell us the priorities. Well, if you do not think they go after each other hammer and tong about what they really need, we have put the peer pressure on them. Then, we take those priorities——

Senator ROCKEFELLER. You get an expenditure target.

Ms. SMITH. Right. We take those priorities and our budget to our Board of Trustees, and we say, this is how these priorities square with the strategic plan of the organization and the needs of the community and what we can afford, do you believe these are the right expenditures. So, they get put in a total budgeting context. But we do not let them pick us off one by one.

Senator ROCKEFELLER. Mike and Jack, is it the same with——

Mr. BROMBERG. One difference for our sector, the investor-owned, is that since we are chains or corporations, there are a couple of layers of buffers and delays and restraints built in that can be used. For example, if all the doctors at a local hospital come and really put the heat on the administrator to go buy a machine for a million dollars, one of the things an administrator can do in a nonprofit or a for-profit chain is say, well, that has got to go up the ladder to the corporate office for a decision, and they are going to want to see a lot of documentation on need, demographic change, revenues, to determine if this is really justified.

So, it gives the administrator a little bit more leverage, at least, in delaying or playing Devil's Advocate. But it basically would start the same way.

Mr. OWEN. And speaking for 5,000 hospitals, there are probably a hundred different ways it goes, but generally it is a medical staff or technology group who recommends to the administrator and the board that this piece of equipment ought to be purchased. And then they look and see whether they can afford it or not.

Senator ROCKEFELLER. Well, that is smoothly said, Jack, but, I mean, that indicates that physicians are making the decisions.

Mr. OWEN. Well, in most cases, the physicians are the ones who use that particular piece of equipment, and the board of trustees, in most cases, is not made up primarily of physicians. And the real test comes when the physician says, this is the kind of piece of equipment that we need in order to provide the kind of care that is community standard.

And it is generally not the nurse or somebody else that comes and says, hey, I read in the paper about this piece of equipment. It usually does come from the physicians, because they are the ones who are generally going to use it.

Senator ROCKEFELLER. Senator Bentsen.

The CHAIRMAN. Well, along the same lines, I have heard it said that the current reimbursement system is enough of a constraint on capital spending to take care of the situation. And yet, there is a feeling that there is excess capacity around the country.

I think the national average bed occupancy rate is about 65 percent. And Mr. Bromberg, you alluded to Texas as having something less, I think maybe as low as 57 percent. Ms. Smith, you can correct me on that, but I think that is about the number for Texas, as I recall. And yet, with your MRI scanners, your PET scanners, there is a feeling that there is an excess in that kind of equipment, too; that there is a surplus there. That there is a competition between hospitals so that each of them has to have all the new technology. How do you answer to that, any one of you?

Mr. BROMBERG. I would like to give several answers to it. One is just a piece of data that I am looking at here. The average occupancy in America right now is 66.2 percent in the last data that is available. Texas is down at 56.6 percent.

The CHAIRMAN. Let me round it off at 57, will you not?

Mr. BROMBERG. All right. The next data is what is the average expenditure for hospital care per person in the States? And the national average is $745 average, and in Texas, it is down at $630.

The CHAIRMAN. Right.

Mr. BROMBERG. So, there is not necessarily a correlation between low-occupancy and high cost. In fact, it looks to me like if you look at the top, New York, Hawaii, D.C., Rhode Island, et cetera, look at some, Massachusetts and Maryland are the highest cost States in the country, and they also have the highest occupancy in the country.

So, number one, I would just say that I think we have exaggerated beyond all belief how much excess capacity costs. This is not like a schoolroom that is empty all summer. It is not being staffed by nurses, or anyone. It is being used. That space is being used for out-patient surgery; it is being used for other services; it is not like that empty bed is sitting there with three employees behind it and a lot of supplies. We have gone beyond that. There is no featherbedding with prospective payment. In the old days of cost reimbursement it might have been a little different.

I also think that in general, on the cost issue, if you look at the hospitals in this country that have closed in the last 5 years—and there are several hundred, many of them happen to be rural and in Texas—they happen to be some of the cheapest——

The CHAIRMAN. We lead the country in the rural hospitals closed.

Mr. BROMBERG. Yes; 60 percent or more of the hospitals in the country that closed were rural. They were generally low-cost hospitals. We could argue about quality, we could argue about convenience, and all the other things. But they were low-cost. And if we start closing hospitals with excess capacity, I think what we are going to find is that they were cheaper hospitals we just closed, and those patients are going to wind up at more expensive hospitals and that this is not a way to save money, to close a lot of small hospitals.

The CHAIRMAN. But you still have not directed yourself to the question I asked regarding duplicative, very expensive equipment side by side. There is no doubt that is happening.

Mr. OWEN. Let me, Senator. One of the things I have watched, the hospitals that were built a number of years ago, most of them under Hill Burton, it was a different way medicine was practiced, and the small hospital was not running at 56 percent occupancy, it was running about 85 or 90, and we put people in the hospital and we thought that was a good place for a physician to see them all at one time, he would come in, he would see all of his patients, and they really did not need to be in that hospital. But as we started into this DRG program, and we said we are going to pay for a specific kind of diagnosis, and that diagnosis does not have to be in the hospital, and we saw that movement out of the hospital.

Now, that was a good thing to happen in one respect, because we are taking care of people where they would most benefit—out-patient clinics, whatever the case might be. But what it did is it looked like we emptied a tremendous number of beds, which we did, in this country. And the question really is now that these beds are emptied, how much is that costing?

And I think what Mike is saying is that it is not costing as much as what it looks like on the outside, because nobody is paying for it, in a sense. But there are some things that are still there that need to be taken into account, and that is the debt that hospitals went into at a time when they thought things were going to continue the way they were. And we are going through a very changing situation.

And the question is how to make that change with the least amount of disruption to communities. Because what happens in a rural community when the hospital closes, the doctor goes. And then access disappears; a point of access.

And the question is, can we afford to have a small hospital with some very expensive equipment in it to be a point of access. And I think you are absolutely right in questioning that, but we have got to figure out a way to get that access to the people out there. We have not done that yet.

Ms. SMITH. I think there is another element in this that gets forgotten in the discussion, and that is that occupancy is really the wrong measure of what we do now. We have had such an enormous transition to short stay and out-patient services, occupancy measures—who happens to be in a bed at midnight—a lot of those people are going home earlier.

So, that bed may have been occupied one or more times during the day. In fact, people accuse me of running a hot sheet operation at times, because we have so many people occupying the same bed

during the day for observation and recovery from various treatments.

I think another important element is that we are now diagnostic in treatment centers, and that capital expenditure in the equipment, in the technology, is what is being used, and used dramatically.

In order for us to treat people efficiently, we need to have enough capacity that we can move them in and out rapidly and not keep them the extra day because they cannot get their CT scan until 2:00 a.m. I learned a very important lesson in visiting Motorola in how they had become a high quality, low-cost producer, and it was that they over-invested on the capital side and, in fact, had excess capacity. And that enabled them to improve their throughput dramatically. They were much more efficient. They were not piling up inventory at each stage of the production process waiting to get access to those machines.

We can use the analogy in health care that we have people warehoused in beds waiting to get access to treatment and technology. If we do not have enough of it, the lack of the CT scanner or the other technology becomes the bottleneck that keeps the person in the hospital longer, getting more of the diagnostic and other nursing care, because they have not gotten the key therapy in a timely fashion.

It also costs us more money to provide that same service at night or weekends, because we are paying premium high-priced wages for those professionals to work at the hours they do not want to work.

So, operationally, which is where 9 out of 10 of those dollars are, if we do not have the capital to get people through in an efficient manner, we are costing us and the system much more money than we need to. So, again, I think that we have a solution with this rule in search of a problem that is not the real problem.

The CHAIRMAN. You are talking about Motorola, yet, I saw General Motors now goes on three shifts in one factory to use that equipment and keep it going all the time, rather than just doing it at the time of convenience of the worker. That is the other side.

Ms. SMITH. Yes. We are working three shifts. What we are finding is that it is very hard to get the skilled professionals to work those other shifts with the shortage of health care manpower.

The CHAIRMAN. I am sure that is right. Thank you.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I thank all of you very, very much. That was helpful, and you were patient.

Mr. OWEN. Thank you, Mr. Chairman.

Mr. BROMBERG. Thank you.

Ms. SMITH. Thank you.

Senator ROCKEFELLER. Our final panel is Jeptha Dalston, who is president and chief executive officer of the Hermann Hospital in Houston, TX, representing the American Association of Medical Colleges; Thomas Lugar, who is chairman of the board of Methodist Hospital of Indianapolis, representing the American Protestant Health Association; and also, Donald Wilson, president of the Kansas Hospital Association.

STATEMENT OF JEPTHA DALSTON, PH.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, HERMANN HOSPITAL, HOUSTON, TX, REPRESENTING THE AMERICAN ASSOCIATION OF MEDICAL COLLEGES

Dr. DALSTON. Ready, Mr. Chairman?

Senator ROCKEFELLER. Yes. I am ready for you. Go right ahead.

Dr. DALSTON. Thank you. Mr. Chairman, members of the committee, you are about to hear from another casualty—Senator Durenberger coined the phrase. So, I would identify myself straight away as a casualty for reasons I will describe.

I am Jeptha Dalston, president of Hermann Hospital, Houston. Hermann is a member of the AAMC Council of Teaching Hospital Centers, and I appear today on behalf of my hospital and my trustees, as well as the nation's major tertiary care teaching hospitals.

I have been editing my comments here so as not to be repetitious of the good points made by others, so what I will do is to concentrate on the most important thing, I believe, for me to say, which number one, is the circumstance of my hospital; what there is about this regulation that is very troublesome to us at Hermann; and what it will take to make the regulation good.

First, a brief description of Hermann Hospital. We are a private, not-for-profit teaching facility, inner city, full-service. We provide a major charity care program, part of it is mandated by our State Attorney General, whereby we provide 10 percent of our patients' care at no cost. They receive a letter upon admission that they will receive no bill.

In addition to that, we are one of the 10 largest Medicaid providers in the State. The two combined, the charity care program and the Medicaid, bring about 26 percent of our patients being uncompensated.

We maintain a very high occupancy level. We have talked a good deal this afternoon about occupancy. I wish to make the point at the outset that there is not idle capacity at my hospital. Indeed, we have all the patients we want.

The difficulty is that most of them have no means of payment. Our travail is to have enough paying patients to offset the burden of the non-paying patients, and daily we run the risk of being literally overrun by uncompensated patients.

Our patient population is sicker. We have a Medicare case mix index of 1.6. We are a disproportionate Medicare provider with a 39 percent share factor. We train over 300 medical residents and interns, and we provide an environment for medical education and biomedical research.

Now, given these characteristics, I wish to relate this hospital and others like it to the regulation. We have supported the prospective payment system. We are supporting the concept for incorporating payment for capital into the PPS. We have all been working toward that, and we expect it.

But the characteristics that I just described, that is, high occupancy, extensive community service, and quality medical education, should not be the characteristics of the hospitals penalized, and that is exactly what is going to happen in our situation. We should not be the targets of this effort.

I will now demonstrate why we will get hurt, why we should not get hurt, and how we believe that that hurt can be prevented. Using the HCFA capital payment model, our hospital will lose $2.5 million in Medicare payments during the first 5 years of this proposed regulation's implementation. This loss reflects capital costs that are already in place. The greater difficulty here, and the greater hurt, is the $8.2 million loss which Hermann Hospital will experience as it proceeds with a mandated patient replacement project.

We are calculating these numbers based upon our best information. That is, the 2.5 based on existing old capital, and the 8.2 based upon a new project. I wish to note that it is very difficult for us to have a clear picture of what those figures will be. I will say more about that. I just want to give you our best estimate at this point, and then come back and discuss the figures themselves in a few minutes.

Hermann Hospital has been doing the right things in trauma care, pediatric care, many Medicaid patients, a high occupancy, active medical education, and it is about to get clobbered by the regulation in its present form. Let me describe our situation of how we are going to get clobbered.

Three years ago, the local health department and our Texas State Health Department, and the Joint Commission on Accreditation of Hospitals all condemned a 1940's building which houses our obstetrical service, our pediatric service, and our trauma care. Continued existence of these programs is wholly contingent upon providing new facilities for them. This is not an expansion, it is a replacement of project.

We formulated the project, we did the planning, we estimated the costs. And we now know that it will take about $100 million, and we are ready to proceed with a bond issue and with a capital campaign in order to finance that project. Our difficulty is that this regulation will not allow us to carry the debt service of the project.

Now, you might ask why did you not do this before? Three years ago, the building was condemned. We did not do it before for very important reasons. The first is our indigent care program—the 10 percent that I mentioned—has been a terrible financial drain on us.

Secondly, we operate one of the two trauma centers in our city, and it is very high cost. And we have taken an increasing number of patients from the public system that has the other trauma service that we have had to finance.

That has amounted to an aggregate cost of about $22 million per year; our own charity care program, and the patients from the public sector. We have had a substantially increased amount of care to Medicaid mothers with reduced Medicaid funding in our State. And finally, the fifth reason has to do with a deep Houston recession.

Those five reasons have put us into a very tenuous financial situation over the past 3 years. We have actually come to the brink of financial insolvency. We found our bond rating lowered two levels; we found ourselves in technical default of our existing bonded indebtedness.

Now, through very expansive expense reduction and other extraordinary efforts, we have managed ourselves out of that situation. The hospital has righted itself, we are now financially stable.

The prospects for restoration of our bond rating are good, and we are ready to proceed with this replacement project through the tax-exempt bonds and philanthropy.

This regulation as presently formulated, however, has put us into financial jeopardy so as to block the project. We will not be able to proceed if the regulation goes into effect in its present form. This will close our Hermann Women's Center—6,000 deliveries per year—it will close the Hermann Children's Hospital, and it will close the Hermann Trauma Service, one of two in a city of 3.5 million people. These services should not be lost to the citizens of Houston; a remedy is called for.

In the way of remedy, I would make just a brief reference to the 10-year period of relatively low capital expenditure in which we have been engaged and reaffirm the same points made by others testifying that hospitals' capital moves in cycles. Sometimes the cycles can be planned, and sometimes they are imposed.

In our instance, you can see, for the reasons I have stated, we have had great difficulty in planning when we would do this. We are now ready to proceed with the project. We have invested some $300,000 to date on out-of-pocket costs associated with the project.

These costs are attributable primarily to architectural and planning fees. We expect the project to be completed in 1994 if we begin this fall, as we had planned to. Therefore, a significant mandated capital project would proceed under way if the capital could be recognized under the regulation. But as presently formulated, it would not be. Moreover, under the HCFA proposed formula, Hermann's capital payments would be determined using the "hold harmless" provision. By year 6, the "hold harmless" methodology will result in capital payments based 100 percent on the Federal rate with no recognition of our hospital-specific actual cost. The proposed move to a Federal average which is less than Hermann's current cost per discharge payment would be counter to our trend in actual capital usage.

The "hold harmless" sounds good when I hear Gail talk about it—and she has been very good to us, by the way. She has collaborated with us, she has consulted with us, she came to Houston and talked with us.

And the more I have heard about "hold harmless" the better it sounds. It sounds like a full course meal. But when I get to the effects of it, I find only yesterday's potatoes. There is just not enough there. And we have come to call it a "hold harmful" clause, because we cannot see where the "hold harmless" is there.

There are two major problems here. The first is the sheer complexity of this regulation, the second is the financial jeopardy that it puts our institution into. The complexity makes it virtually impossible to calculate the financial effects. I mentioned earlier the 2.3 and the 8.2. That is our best estimate. But we really do not know how much this is going to cost, and it makes me feel as though I am flying a 747,600 miles an hour with a 100-foot visibility, with little instrumentation; I do not know where I am going.

And you asked earlier, Senator, "who approves capital projects?" In our hospital, it is our board. But our board is not going to proceed with this project if they cannot see the clear financial underpinnings and that it is a prudent business investment. The regulations right now would have it not be a prudent business investment.

Senator ROCKEFELLER. Sir, you are going to have to wind up here.

Dr. DALSTON. Yes, sir. Remedies. First, the remedy that will allow Hermann and hospitals like it to exercise a one-time option of a waiver, either a blended transition rate in the direction that Senator Hatch mentioned earlier, or Senator Durenberger's 7-year rolling plan that Mike Bromberg described, either that, or a real "hold harmless" rate that gives us some safety net, some way to avoid financial disaster as we might proceed with this mandated project. The second part of the remedy is the indirect medical education adjustment that the AAMC has included in their testimony, and I will not take the committee's time to go through that.

In conclusion, we support the prospective payment system. We support the capital fold-in. But this regulation will defeat the mission of our hospital in its present form.

We will not be able to replace our obstetrical facilities, our pediatric facilities, and our trauma service; we will not be able to go forward with the charity care program for 10,000 Houston citizens each year; we will not be able to serve as the core teaching hospital for the University of Texas; and we will not serve the people of Houston as we now are. This regulation really needs modifications along the lines I have recommended. Thank you for the opportunity to be here.

[The prepared statement of Dr. Dalston appears in the appendix.]

Senator ROCKEFELLER. Thank you, sir. I think Senator Bentsen has a question.

The CHAIRMAN. I just spent an afternoon at Hermann, and you have a great facility. But you are talking about a variance in what has been proposed between the blended transition and the "hold harmless." And, as I recall, you stated you had about an $8.2 million loss.

Dr. DALSTON. Yes, sir.

The CHAIRMAN. How would this change, this variance that you are talking about affect your loss?

Dr. DALSTON. It would move the loss to a lower figure. There would still be a loss there, but our calculation, something on the order of $1.5 to $2 million.

The CHAIRMAN. Well, I would very much hate to see you close that trauma center, and yet, I can understand what you are faced with. And as I understand it, if this proposed capital limitation was put into effect, I assume that means you would close your trauma center. What happens with your renovation? Do you put it off, or do you stretch it out?

Dr. DALSTON. We simply could not do it, Senator. And the reason the trauma center would close is because the health department would mandate it. It would not be a voluntary closure.

The CHAIRMAN. That would just leave you, what, Jeff Davis?

Dr. DALSTON. No, sir. It would leave us two of our——

The CHAIRMAN. Trauma centers. Trauma centers.

Dr. DALSTON. Oh. I am sorry. Yes. That is right.

The CHAIRMAN. That is all you would have left.

Dr. DALSTON. It is. The Ben Taub Hospital would be the only trauma center in the city.

The CHAIRMAN. Yes. Ben Taub. Right.

Dr. DALSTON. Ben Taub.

The CHAIRMAN. All right. Thank you very much.

Senator ROCKEFELLER. Thank you, Senator Bentsen. Mr. Lugar.

STATEMENT OF THOMAS LUGAR, CHAIRMAN OF THE BOARD, METHODIST HOSPITAL OF INDIANAPOLIS, INDIANAPOLIS, IN., REPRESENTING THE AMERICAN PROTESTANT HEALTH ASSOCIATION

Mr. LUGAR. Good afternoon, Mr. Chairman, and Senator Bentsen. I am Thomas R. Lugar, the chairman of the board of directors of Methodist Hospital of Indiana.

Senator ROCKEFELLER. Are you related to Senator Lugar?

Mr. LUGAR. Yes, sir. Brother. And I am glad to hear that you were in the Chair at the Senate this afternoon, because I had a chance to have lunch with my brother.

Senator ROCKEFELLER. Well, he is one of the finest men that I have ever met.

Mr. LUGAR. Well, thank you very much. We are very proud of him.

I am accompanied today on my left by John Fox, the senior vice president and chief financial officer of the hospital. It is a pleasure to be here on behalf of the American Protestant Health Association. The APHA commends you for the leadership you have shown, Mr. Chairman, and your willingness to confront this issue. We applaud Dr. Wilensky and her staff at HCFA on the open process used in developing these regulations. Although we continue to believe that no change from the current system is necessary, we believe the proposed rules, together with the changes that were proposed today, will be workable.

The American Protestant Health Association is a national association of church-related, not-for-profit hospitals and health systems. APHA represents nearly 500 institutions, including major teaching, disproportionate share, small urban and rural hospitals.

Methodist Hospital of Indiana is a not-for-profit, general and acute care teaching hospital and a member of the American Protestant Health Association. It is the largest hospital in Indiana, and based on admissions, it is the eleventh largest in the United States.

Methodist, which operates at approximately 87 percent capacity, anticipates in-patient and out-patient volume to grow over 10 percent over the next 5 years. We are a very well-utilized hospital.

Methodist Hospital made an historical commitment to remain in the inner city where we provide to our community $27 million annually in charity care. The only reason we do not qualify as a disproportionate share hospital is due to a quirk in the State payment mechanism.

The proposed change in the Medicare capital payment policy will have a negative impact on Methodist Hospital in the amount of approximately $20 million over the next eleven years, and will se-

verely limit our ability to provide quality health care to our community. There is no need to repeat our comments which you received in written form, and we will therefore focus on four major points.

Most importantly, we must be able to plan ahead and know what we are getting with a reasonable degree of certainty. There should be a real "hold harmless" provision either mandated by the Congress, or adopted by the final rule.

We agree with those who have testified previously that a permanent payment floor should be imposed so that no hospital receives less than 80 percent of its capital costs.

The inherent problem of imposing an average capital payment policy on all hospitals is that all hospitals are not the same, especially with regard to capital. Capital is cyclical in nature and it affects each hospital differently.

While changing the definition of "old" capital to include capital assets committed by September 30, 1991 and completed by December 31, 1994 is helpful, we believe that major regional treatment centers and teaching institutions with high occupancy rates, such as Methodist Hospital and other members of the APHA, must be protected.

To do this, we suggest that hospitals be allowed to elect on a one-time basis not to go under the "hold harmless" provision, but to be paid under the fully prospective payment methodology blend.

Depending upon a hospital's capital cycle and patient acuity, a one-time election to go directly to the blended prospective system could accomplish the goal without disturbing budget neutrality or creating uncertainty in the system. Our belief is that a very small number of hospitals would opt for this.

As a third point, the Secretary's discretion to unilaterally determine and implement the capital update must be circumscribed. Specifically, the methodology must provide for updates that reflect the true increases in capital costs each year.

Also, in the proposed rule, transfer patients appear to be counted as two discharges; one at the transferring hospital, and one at the receiving hospital. Inclusion of transfer patients substantially dilutes the standard Federal payment rate to large, non-transferring institutions.

Under this rule, a conflict may exist for some hospitals whether to keep and treat a patient, or to transfer the patient, possibly putting the patient at risk, and resulting in added expense to the Federal Government and to the institution receiving the transfer patient.

We suggest that the transferring hospital receive a payment representative of the services consumed at the facility similar to the DRG payment for transfer patients, and that hospitals receiving transfer patients be reimbursed the full capital payment.

I would like, maybe, to avoid the rest of the written papers here and just verbally say that I think our request is that we be treated fairly. We have heard in testimony earlier today that these new regulations are designed not to hurt anybody. They say that this implies that if you are a large hospital with large occupancy, and inner city, and large teaching, that you are not going to be hurt.

But we are going to be hurt, to the tune of some $20 million. Others have testified here today to a larger degree.

But likewise, it was discussed earlier that we have had years to plan for this. I think our board is a businesslike board, been very prudent. We have not planned for this by going out and spending unnecessary capital. I think we have been very diligent. I think we have been caught. In conclusion, I hope that we will not be a casualty of friendly fire in all of this.

So, Mr. Chairman, we appreciate the chance to be here today. Mr. Fox and I would be glad to answer your questions later on. Thank you.

[The prepared statement of Mr. Lugar appears in the appendix.]

Senator ROCKEFELLER. Thank you, sir, very much. Mr. Wilson.

STATEMENT OF DONALD A. WILSON, PRESIDENT, KANSAS HOSPITAL ASSOCIATION, TOPEKA, KS

Mr.Wilson. THANK YOU, SENATOR ROCKEFELLER. My name is Don Wilson. I am president of the Kansas Hospital Association. While recognizing that this regulation affects all hospitals, I will focus primarily on rural issues during this testimony.

It has been projected in Kansas that we will experience a 17-percent increase in the number of people over 65 by the year 2000. That increase is over and above of percentages that we have in many of our rural counties that are already approaching 30 percent, and most are between 25 and 30 percent.

So, the availability of good, primary health care is very important to rural Kansas, and we have worked very hard during this last decade to try to assure that the citizens of Kansas, especially the elder citizens of Kansas, have access to these services.

We are proud to have been put in a leadership role to develop the swing-bed program during the demonstration grants that were given by the Robert Wood Johnson Foundation. We are working very hard now to be prepared to do likewise for the RPCH demonstrations that will be granted in the next few months. That has been going very well, and we have been exceedingly pleased with the receptivity that our hospitals have shown in networking and putting together the proper mechanisms to be prepared for that program. We have 138 community hospitals in Kansas; 116 of those are rural hospitals.

I think it is kind of interesting, we were sitting down the other day going through some of this testimony and we were brainstorming some of the things that have happened since the beginning of the prospective payment system.

One of the things we looked at is what changes have occurred, and we started counting. We have sole community providers, we have rural referral centers, we have Medicare-dependent hospitals, and now we have a group of geographically reclassified hospitals.

We started counting that up, and even though we could not get an exact number, about 75 of 116 rural hospitals are currently off mainstream PPS in some fashion or another because of a problem. The reason being the conventional system just did not work adequately because of the tremendous variations we have in rural America, particularly with our hospitals. And I think we probably

have that similar concern or paranoia as we go into the capital program because we ask is it a program that will affect our hospitals equally and equitably as they go about assessing their future capital needs?

I think we all recognize that in the early stages of the program, most rural hospitals are going to benefit. At least, they are going to receive more money than they currently receive under the existing program.

That is what appears on the surface, people have said they are going to come out winners. And I guess if they maintain their current status and they can continue to exist in facilities that are many times 30, and 40 years old for a long period of time, that may be true.

Earlier discussion today was that these hospitals are strapped for cash. A lot of the extra money, if they do receive it, will probably be used to shore up operations and to just continue to see if they can maintain the ability to continue to provide services.

But on the other hand, if you look at the fact that this regulation is designed to provide for the capital needs of these facilities, then I think we need to look at what the impact of the regulation is on some existing situations. One of our analyses was to model a recently completed project that, fortunately, will be protected under the "hold harmless" and old capital provisions. In other words, this hospital did their replacement at the right time.

We took this hospital and said, all right, now what would happen if they tried to do this project after the rule was put in place?

It was a rather modest project, about $2.5 to $3 million, financed by the Farmer's Home Administration with about a 6-percent loan. Right now, that hospital's needs are about $900 per discharge to take care of that capital responsibility.

If that hospital were to do that project today, the results would be quite different.

Currently, the median capital costs per discharge for 11 similar rural Kansas hospitals that reported to a national data bank was $293.31. On the surface, the payment rate that they will receive under the proposed rule of $412 looks quite attractive, but that is only if conditions remain constant. If they were faced with a debt responsibility of $900 per case like the previously cited hospital, and were looking at a reimbursement factor of $412, they would not consider that very attractive.

I think they would feel they had a significant problem. Even if they qualified for all of the exceptions within the rule, which our folks have estimated would, perhaps, put that rate up to $630 per case, they still fall fully a third short of meeting that responsibility.

I think the concern that we have with the rule is that we want to be assured that within that rule, if hospitals need to replace their facilities, if they need to assure that the citizens of their area are going to have access to primary care services, that that process is available; that there is a procedure that can be used for them to demonstrate that need.

There are several inequities, but I would just like to focus maybe on one that has been mentioned again today, and I think it needs

to also be maintained in front of the committee; and that is the use of the area wage index.

We did a little survey of several of our rural hospitals that have been involved in capital projects, and most of the labor, for example, that is used on those projects does not come from the local community. In fact, it does not come from a rural community. It generally comes from one of our urban centers where the construction companies are located. Obviously, when they buy major equipment purchases, that is not financed by local labor, but from some other part of the country.

So, we recognize the frustration that, perhaps, HCFA has experienced in trying to figure out a reasonable proxy here, but we do also feel that there are great inequities in using the area wage index to determine the rural payment rate.

We really would hope that lawmakers would be sensitive to the fact that we do have some great concerns that if hospitals—particularly our rural hospitals—make that decision to replace themselves, there will be adequate financing available. Thank you.

[The prepared statement of Mr. Wilson appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Mr. Wilson. Let me ask a generic question to all of you. CBO has compared the availability of technology in the United States and Canada, and what was West Germany. And they indicate, not surprisingly, that the U.S. has a much greater capacity. For example, the numbers of open heart surgical units per million people were 0.7 in West Germany, 0.12 in Canada, and 3.3 in the United States. They indicated that the U.S. has 3.7 MRIs per million person, compared with 0.9 in former West Germany, and 0.5 in Canada.

Now, we are all familiar with the shortcomings of the Canadian system, and we understand that Americans are different and wish different types of services. Nevertheless, this has something to do with cost.

I am not so sure—in fact, I think I am quite sure, because I have never really had anybody argue the other side of it persuasively—that we do not have quite a bit too much technology. That could maybe apply to some places more than others, but I think as a general statement about the medical situation in our country, that is a fair statement.

And I think that it is fair to say that doctors order too many tests; we know that. The degree, the percentage people dispute, but nobody disputes that that happens. And they often do so just because the technology exists it does not have to be related to defensive medicine, it is just that the technology is there. I had an interesting situation in my own office where two of the women who worked there were pregnant. One belonged to an HMO, and the other had a regular commercial insurance plan.

They were both very healthy young women, and every time the HMO person went in, the doctor said there is no need to take a sonogram. Had one there, but there is no need to take it; perfectly healthy, just come on back in a month.

Every time that the one that belonged to the non-HMO went in, she got the sonogram. So, it is there. It is there and the results of that scientific survey are very clear, and the bills that resulted from them.

I think it is especially relevant when you consider that both West Germany and Canada have substantially better infant mortality rates than we do, and substantially longer life expectancies than we do.

Now, my question is, do you think we are getting our money's worth from technology in this country, and to the extent that this question applies to your own hospitals, what do you think that you ought to be doing about it? That is two questions. Are we getting our money's worth? And if the answer is, perhaps, no, what should you be doing about it?

Dr. DALSTON. I will be glad, Senator, to dive into that. No, I do not think we are getting our money's worth. I think there is a lot of inefficiency in the system. There is excess technology and there is a better way to do it.

I believe, if I could expound on that just for a moment, that that is a function of the climate in which we are functioning, that is, the entrepreneurial era.

The free enterprise health care system that we have in this country encourages us to make those investments just that way. And as long as we continue to have that climate, that environment, I think we will continue to do it.

Senator ROCKEFELLER. Well, let me stop you on that. Now, what forces you to make that decision? Is it because somebody across town has an MRI, so you have got to have one too?

Dr. DALSTON. Competition, yes, sir. If I want to keep my paying patients, I have got to have whatever will bring them there, or the doctors who will bring them there. And if the doctors apply that leverage we discussed earlier this afternoon, and I do not meet the competition, they will go away. I have experienced that. I experience it every day. And we live on a thin margin of financial survival in my particular situation, so we are acutely attuned to this matter. And we make our investments carefully, but we sure do make them. And we do not make them in the interest of the city, always, or society; we make them in the interest of our survival.

Senator ROCKEFELLER. All right.

Dr. DALSTON. Then, what do we do about it? What we are trying to do is to change the way that medicine is taught and practiced in concert with our university, because we believe that the way to get at this is through patient acquisition and patient franchising.

That is to say, if we can have a guaranteed number of patients, then we can be more efficient in what we do. In a larger sense, in an acuity sense, if there were a system afoot here that motivated us to have patient franchising, we would organize ourselves into systems of health care. And each system then would have its technology, but not everybody and his brother on every street corner would have the technology—oversimplification, but I am trying to be brief.

Senator ROCKEFELLER. In the first part—I will go on to others of you in a moment. You really tossed that off very easily. In other words, competition demands it, therefore, I am going to do it. Now, if health care costs are going crazy in their upward spiral, what you just said has the seeds eventually of your own destruction, does it not?

Dr. DALSTON. Yes, it certainly does. Yes, sir; it does. And I do not like it one bit.

Senator ROCKEFELLER. So, what do we do? Go to a single payor system?

Dr. DALSTON. Well, we are going to go to some kind of system reform, and maybe that is it. I would prefer to change the way that we organize for delivery of the services to be more efficient, and I would prefer that we have public policy that stimulates that at the local level and lines up doctors and hospitals in productive ways, as opposed to counterproductive ways. That is what we have been trying to do.

Senator ROCKEFELLER. For example?

Dr. DALSTON. For example, if business had economic incentives to contract all of its employees with a single hospital system, then we would come together, because there is no way to get the patients otherwise, because the patients are owned by the contracting system.

And again, I do not mean to speak too globally here, but that is the direction in which we are trying to go with managed care with our university practice plan, our doctors in private practice, our hospital, and suburban hospitals. And they would contract with big business and with government to provide care to patients in large numbers.

Senator ROCKEFELLER. Now, when I spoke earlier of the New York Times and managed care, I certainly did not want to give the impression that managed care is not terrific. I mean, it is absolutely an essential part of cost containment. But what about the others? How many other hospitals are there that you are competing with in Houston?

Dr. DALSTON. There are 5 or 6 like us that are our major competition.

Senator ROCKEFELLER. So, there are about six hospitals that compete for the business of three and a half million people. I do not know how one figures this. Is six hospitals, about six hospitals, too many hospitals for 3½ million people, or too few hospitals, or just about right?

Dr. DALSTON. I would say it is just about right. I would not argue that. I think it is the way we are organized that is wrong.

Senator ROCKEFELLER. Are they all doing the same thing? Are they taking a managed care approach, and are you, therefore, competing within that new health care delivery system?

Dr. DALSTON. Not to the same extent in our city. Not to the same extent.

Senator ROCKEFELLER. Now, if you are able to deliver services at a lower price, which you will be able to do if you have sufficient numbers of people under a managed care system, under the free enterprise system will they not notice that and have to respond to that?

Dr. DALSTON. That is our strategy, and that is the market niche that we are going after. But we are having a heck of a time getting there, because the incentives are in another direction.

The incentives are for the doctors to continue to private practice; the incentives are for business to contract employees to everybody

all over town. Those are the kind of disincentives that I am referring to.

Senator ROCKEFELLER. How do you try to overcome that as you try to put the system in place?

Dr. DALSTON. Organizing a package, a program, to present to business and sell it to them. That this is——

Senator ROCKEFELLER. To the physicians.

Dr. DALSTON. No, to the business.

Senator ROCKEFELLER. Yes, but you mentioned that physicians are difficult to hold in.

Dr. DALSTON. The only way we can get the physicians is to get the patients. If we are not going to compete through technology, and that business we were discussing earlier, I have got to have the patients in order to get the physicians. As long as they have the patients, they control me; I do not influence them.

Senator ROCKEFELLER. All right. Mr. Lugar.

Mr. LUGAR. Yes, Mr. Chairman. I would like to maybe address the first part on the money's worth, and then turn it over to my associate, Mr. Fox, on what do we do about it. But I think you raise a very good point. I think here it depends upon where you are coming from as to whether you are getting your money's worth; whether it is the taxpayer or the hospital administrator. Obviously, if you are a patient and you have got this heart transplant, you have got your money's worth, and I think there are many grateful people. And I think there are difficult decisions here and research and development coming on.

I think we cannot stifle the research and the development of new products and new tools and new techniques, but we had better be very prudent about how many we get and who gets them.

I think in our case, we have done a good job there in the Indianapolis area. I think some groups have got one big piece of equipment. The other hospitals and we have not launched out to say we want to compete just because you got this. I think it is a very prudent business way to go, and I think we are getting our money's worth. John, would you like to address this? What do we do about it?

Mr. Fox. Well, just a couple of brief comments. The first point on the open heart operations around the country and the large number of them in the United States, Methodist, for example, was one of the first ten hospitals in the country to be approved by HCFA for doing Medicare transplants, and had to jump through a lot of hoops to obtain that level of credentialling. That is not required for a lot of Medicare hospitals to get into the open heart business for Medicare beneficiaries, and where a place like Methodist will do over 1,000 open heart operations in a year, there are many facilities that are doing 200 or 100 procedures a year.

It is clearly shown that the ability to do these procedures effectively is a function of volume. If you do a 500 or 1,000 a year, your mortality/morbidity statistics will be substantially better than if you are doing 200 or 100.

I would direct Congress or HCFA to look towards that to see whether you are getting your money's worth. And if you are throwing a lot of dollars at high technology/low volume hospital operations, they really are not serving your interests well.

You have some history for evaluating specific programs in institutions based upon their ability and their volume, and going more to that model where you spent a lot more dollars in the area of open heart, and in ophthalmology and others areas, might yield you some substantial savings in dollars, and certainly some better quality.

Senator ROCKEFELLER. All right. Thank you, Mr. Fox.

Mr. Wilson.

Mr. WILSON. Well, I do not really have too much to add, except, perhaps, one other aspect of this whole technology dilemma is that as the public becomes better educated about the technology and develop their set of expectations, I think it does put, to a certain extent, physicians in a bind.

I had a recent experience in the last couple years where one of my sons had significant headaches; they were very, very serious. We went to the neurologist. He did an excellent job of doing a physical assessment. He convinced me and my son very well that these were probably migraine headaches.

But at the end of the visit, he said, now, the probability is extremely high, 990 out of 1,000 cases that this is what your son has. But, if you want to be sure, you can have a CAT scan, and if you want to be real sure, you can have an MRI.

Now, he did not say we had to do it, but I felt that he really did not have much option but to say that it was available to us. I think he was protecting himself, obviously. I think maybe we need to be looking at that part of it, also, maybe with some of the tort reform issues because I think they do throw that option out, and for very good reason.

Senator ROCKEFELLER. I did not hear the part from Mr. Lugar and Mr. Wilson about what hospitals should do about this problem. The second part of my question.

Mr. FOX. That was delegated to me, and maybe I was remiss.

Senator ROCKEFELLER. That is an ominous sign right there.

Mr. FOX. That is right. Mr. Chairman, what we believe is the solution is going to be something similar to what the representative from Hermann Hospital is proposing, mainly, that of competing delivery systems.

What you have in American medicine right now is the inheritance of an old cottage industry of a lot of individual physician practices now forming more group practices that are out there as separate, independent, economic organisms pursuing their own interests.

Then you mix that with the demographic and technology changes going on in the big business known as medicine today, and how hospitals play a role in this. And this is all taking us someplace where we never expected to go, because it does not seem like there is any control or management over the system.

What we believe is going to need to take place, and what we are moving towards, is being a competitive delivery system whereby an insurance carrier, the Medicare program, or employers can come to us directly and say, we wish you to provide us health care.

And if our employees have the sniffles, you will take care of them, or if they need a heart transplant, you will take care of them. Now, we can do that, because we are a 1,000 bed hospital

with over 1,000 doctors on staff, and we already have every toy known to man, in terms of medical equipment, in our facility, and can serve that type of function.

And we currently do over $100 million a year business on what would be described as a totally capitated method where we basically take a dollar from an employer or a program and say we will provide you with health care, and we basically manage the delivery of health care in terms of its efficiency and efficacy within those dollar parameters and, we think, at very high quality. But we still do $400 million a year business, or the other 80 percent on the old model, which is the fee-for-service model. And clearly, the old world is dying. The fee-for-service model is fading away, because it is not going to be able to deal with controlling health care costs in the new world that is emerging. And our challenge, frankly, is to manage the transition period so we do not get crushed between those two worlds.

Because, again, we have to compete with being an attractive place for physicians to come to and to bring their patients to for that segment of the health care economy that still functions off of that fee-for-service model, but at the same time, we are working very diligently to build up our infrastructure as a competitive delivery system, where basically you come to us with one dollar, if you will, or your premium dollars.

We take care of paying the physicians and providing all of the health care services, hospital, ambulatory, and otherwise, within our delivery system.

Senator ROCKEFELLER. Mr. Wilson, before you answer, do the 3 of you—can you answer the question what is the increase in the cost of health care in your particular hospitals over the last 5 years? Do you have figures for that on a year-by-year basis?

Dr. DALSTON. Yes, Senator, I have those. I do not know whether I have them precisely in my head, but I certainly have a trend line in mind, if I understand what you are asking.

Senator ROCKEFELLER. Yes.

Dr. DALSTON. But that is a very important measure of our operation that we follow very closely.

Senator ROCKEFELLER. And what are your figures?

Dr. DALSTON. Our figures are just about at the CPI market level, and we have undergone very extraordinary expense reduction, for the reasons that I have stated in my testimony here.

So, that may be unusual. We do not have many services—not medical services, but other kinds of support—administrative services in our hospital are normally found. So, our expense line is quite low. But it is about the CPI at our hospital.

Senator ROCKEFELLER. Gentlemen.

Mr. LUGAR. Yes. In the past year, our operating budget went up approximately 6 percent. I think in the coming years this will hold. To help to contain costs, we have undertaken for the next several years a new cost improvement plan which, hopefully, will lop some $30 million off our costs. And I think we are very conscious that the costs have to be contained, and we are going to do it.

Senator ROCKEFELLER. Mr. Wilson.

Mr. WILSON. I do not have any specific numbers, but our evidence is personnel costs. We have a lot of shortages in Kansas. We

are forced, I think, to pay what the market will bear. And the personnel costs are what really do seem to be driving the costs of health care in our hospitals.

Senator ROCKEFELLER. They say that ordinarily the cost of people is about 60 percent of the cost of doing business. Is that about true in your hospitals?

Dr. DALSTON. Yes.

Mr. LUGAR. Yes. That is correct.

Senator ROCKEFELLER. I have been told that at the Texas Medical Center, which is in Austin?

Dr. DALSTON. It is the largest aggregation of biomedical research and patient care in the world, Senator. That is what we are paid to say.

Senator ROCKEFELLER. Yes. But that has 100,000 people working there.

Dr. DALSTON. Yes, sir. That is correct.

Senator ROCKEFELLER. So, when you deal with 100,000 people, that is a lot of cost.

Dr. DALSTON. It is the second-largest industry in Houston.

Senator ROCKEFELLER. Yes. Probably makes the State Government look small. The hospitals, in their fight to compete, have to market themselves. And I have to stop at this question. You are competing with six teaching hospitals, and then there is evidently a total of 57 hospitals in Houston.

Dr. DALSTON. Yes.

Senator ROCKEFELLER. So you are competing with a lot more than that, in some form or other. In that hospitals have to be treated like a business, they are run generally by businessmen, boards are made up of businessmen, so we have agreed that it is not just the competition from the market, but the competition from sources of pride, and other things.

Let me just end with this. You tell me what you would do if you were a Senator or President saying this is what has got to happen in the management of hospitals, including what it is that the government does and does not do to mess up your lives, the hassle factor, and all the rest of it, and all the accountants that you have to hire to take care of our problems, et cetera. But what would you do about this problem?

Now, you are going up 6 percent a year. That is not so bad. And yet, this total cost of health care keeps going out of control, and you are a part of that.

Dr. DALSTON. Yes.

Senator ROCKEFELLER. What part do you play in this? What do you do about this?

Dr. DALSTON. Well, my individual apart, I work very hard at trying to do what I think is the right thing to do, but I believe you are asking the question if I were God, how would I shape this thing.

Senator ROCKEFELLER. Yes.

Dr. DALSTON. I can answer that conceptually. I do not know enough, I am not smart enough about all that is involved to know mechanically or specifically, but conceptually, what I would bring about is public policy that would encourage the maturation of the health care field in medicine. Maturation and consolidation and

putting us into a way of operating that encourages to do what has been said here; to move us to large health care organizations that function in a rational way in competition with each other, but not in competition of such a pluralistic nature that it cannot make sense either to the patient, the payor, or the provider.

I would have public policies that encourage the tax programs of business, that encourage the public policies of government in buying services, and encourage physicians and hospitals and the way they are paid to push us together; to push doctors and hospitals together into large health care systems.

Senator ROCKEFELLER. And you are doing that.

Dr. DALSTON. Well, I am trying, Senator. But my earlier point, it is very difficult.

Senator ROCKEFELLER. Yes.

Mr. LUGAR. I think it was a very good answer. Of course, the question you are asking is the big national debate, I guess. It is, where do we go from here? What is the plan? And I am not sure there is a plan. I think we are going to whittle it. I think we have a good system. I think we are very fortunate to live in the United States. Your earlier figures about Canada and Germany and everything else, that here we are extremely fortunate that we have the hospitals, and the technologies, and the doctors, and the skills. And I do not think we are going to wreck this plan. I think we are going to streamline it. Specifically, we have to contain costs which——

Senator ROCKEFELLER. But do you remember, I put in that thing about infant mortality and life expectancy.

Mr. LUGAR. Yes. Yes. And those are two——

Senator ROCKEFELLER. So, it is not doing everything to help us.

Mr. LUGAR. No, it is not doing everything.

Senator ROCKEFELLER. I mean, living long and getting born are reasonably important things in life.

Mr. LUGAR. Yes. And I think one other we can do is encourage more preventive medicine, better lifestyles. How much in health care is lost through smoking, the tobacco industry?

Senator ROCKEFELLER. Does your hospital teach on that subject? Do you do outreach?

Mr. LUGAR. Oh, yes, sir. We are one of the leaders in the Indianapolis area, and we got the rest of the hospitals to go smoke free in the whole hospital.

Senator ROCKEFELLER. That is good.

Mr. LUGAR. And other hospitals have followed suit. And people said, well, it is going to be tough to do. And I think we made a commitment that this is something that has to be done.

I mean, we have to be a leader. If we are going to do health care, we have to show health care. So, I think some of these other things can help in this, and maybe, John, you would like to add a few more.

Mr. FOX. My comment is simply the move towards competing delivery systems where the piecemeal work of the current dynamic of the health care economy is removed and the buyer is going out and buying from an organization the ability to provide health care to their beneficiaries, whether it is a government program, or a private employer.

That will rationalize a lot of the delivery system underneath and a lot of financial incest that takes place in the hospital/doctor relationships, or doctors buying into MRI scanners, and doing a Walla biopsy on their patients, and then referring them to their operation based upon their financial class, versus another operation. That is all the dysfunction that is currently being injected in the current system under its current structure.

And when it is all handled through this delivery of a single premium dollar to a delivery system, then that delivery system has to organize itself to maximize its efficacy and its efficiency vis-a-vis that revenue dollar, and the system just does not have those dynamics in it right now. And that is what is causing a lot of the dysfunction we are experiencing today.

Senator ROCKEFELLER. Mr. Wilson.

Mr. WILSON. Perhaps even getting back to the second part of the first question, I think the problem that we see that probably creates the most concern is what can you do to promote collaboration amongst the health care community to develop some sensible arrangement of services that is most effective and most efficient for the population that is being served.

Unfortunately, under the current scheme, we find even in our very small communities, many times there exists duplicative services not only in the physician offices, but through the local health departments, just a whole range. That is something that I think we have been discussing at quite some length. How can you bring those services under one umbrella, and how can you make some sense out of them so you are getting the most effective and efficient array of services. But we are seeing, in many cases, many of the out-patient services that our hospitals offer are being duplicated throughout the community.

Senator ROCKEFELLER. So, you are talking about collaboration in health care, and Dr. Dalston is talking about competition.

Mr. WILSON. That is correct.

Senator ROCKEFELLER. Now, what is the difference there?

Mr. WILSON. Well, we probably, in the country, do not have quite the firepower to set up the competitive health systems and all that type of thing.

We would just like to be able to see some set of incentives that would give our hospital communities the opportunity to collaborate and to come together with, as I say, a meaningful arrangement of services that would not be collaboration just amongst the health care community, but bring in the insurers, bring in the business community, and look at what is the best delivery system for that particular population that everybody can agree to, that everybody is comfortable with. And maybe that is pie in the sky, and maybe that is something that is not attainable.

But when we are looking at small populations that need to be sensitive to the efficiency of the services because they do not have a lot of money, we think it is important.

Senator ROCKEFELLER. But you have got other hospitals. How many other hospitals in Topeka?

Mr. WILSON. How many hospitals in Topeka?

Senator ROCKEFELLER. Yes.

Mr. WILSON. Two. Two community hospitals.

Senator ROCKEFELLER. All right.

Mr. WILSON. There is the Menninger Foundation, then there is a State hospital, and a VA Hospital. But there are two community hospitals.

Senator ROCKEFELLER. Yes. All right. Look, I am going to call it quits here. First of all, you have all come from great distances, and I appreciate that. Secondly, you are the last panel, which is a terrible thing to do to any human being. And thirdly, you have been very important in your contributions, not only in your testimony, which is important, but in your comments. Your coming here is not in vain, believe me. We are all trying to struggle to figure out how to make our system not collapse, or stop collapsing. So, I really appreciate it, and I thank you.

Dr. DALSTON. Thank you.

Mr. LUGAR. Thank you.

Mr. WILSON. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you.

[Whereupon, the hearing was adjourned at 5:20 p.m.]

APPENDIX

Additional Material Submitted

Prepared Statement of Stuart H. Altman

Good afternoon, Mr. Chairman. With me today is the Commission's Deputy Executive Director, Laura Dummit. I appreciate the opportunity to appear before the Committee this afternoon to discuss Medicare's capital payment policy—an issue that the Commission has addressed several times over the years.

As you know, the Commission submitted a report on capital payment policy to this Committee on May 15, 1991. The report contained ProPAC's analysis of the Secretary's proposal for prospective payment for capital. It summarized the information ProPAC has been examining on hospital costs for buildings and equipment and the factors that affect those costs.

We were favorably impressed with the Secretary's proposal. We feel that he developed a capital payment method that responds to many of the concerns of the hospital industry, while providing the same financial incentives for capital payment as are currently provided by PPS for operating costs. The proposal attempts to balance the competing needs of protecting historic investment decisions with providing adequate funds for future capital expenditures.

The Commission, however, has some reservations and concerns regarding prospective, per-case payment for capital. Nevertheless, we agreed that the Secretary's proposal, with appropriate modifications, is the best available approach to capital payment policy.

We have attempted to address some of our concerns in the specific recommendations that I will discuss in a moment. In addition, we have continued to examine the actuarial model HCFA used to estimate the budget neutrality adjustment and exceptions payments. We have also been analyzing the revised projections used in developing the 1992 Federal capital payment rate. I will discuss these continuing areas of analyses further in a moment. I also want to add that the Commission plans to monitor the implementation of this payment system and recommend further modifications as necessary.

First, Mr. Chairman, I will summarize the information on capital costs that the Commission has considered over the last year. Then I will discuss ProPAC's comments on the Secretary's proposal. Both of these are described in more detail in the report we submitted to this Committee and the Committee on Ways and Means of the House of Representatives.

CHANGING MEDICARE'S CAPITAL PAYMENT METHOD

Based on our analysis of hospital capital costs and capital payment issues, we concluded that there are several important reasons for changing the current capital payment method. First, rising hospital costs is a justification for a change in capital payment policy. Second, the Commission believes the same financial incentives should be promoted through both Medicare's capital and operating payments. Finally, the current capital cost-minus payment approach is not fair.

Changes in Capital Costs

In the past few years, the rate of increase in capital spending has slowed (see Figure 1). Nevertheless, capital spending continues to increase at about 10 percent a year, at the same rate as operating costs (see Table 1). This is a change from the early years of PPS when capital cost increases were significantly higher. This decrease in the rate of growth in capital spending reflects a decrease in inflation and possibly a response to the current policy of paying less than full capital costs and

48-319 - 92 - 3

the increasing financial pressures facing hospitals as Medicare continues to control payments for operating expenses.

Table 1.—CHANGE IN CAPITAL AS A PROPORTION OF TOTAL COST AND CAPITAL AS A PROPORTION OF OPERATING COST, 1980–1990

Year	Capital/total cost	Annual percent change	Capital/ operating cost	Annual percent change
1980	6.2	−16%	6.6	−15%
1981	6.3	16	6.7	15
1982	6.5	3.2	7.0	4.5
1983	6.9	6.2	7.4	5.7
1984	7.9	14.5	8.6	16.2
1985	8.3	5.1	9.1	5.8
1986	8.4	1.2	9.2	1.1
1981	8.5	1.2	9.3	1.1
1988	8.5	0.0	9.3	0.0
1989	8.5	0.0	9.3	0.0
1990	8.4	−1.2	9.2	1.1

SOURCE: ProPac analysis of American Hospital Association National Hospital Panel Survey.

Just because capital and operating costs have been increasing at approximately the same rate over the past few years does not mean, however, that capital costs are under control. Further, the prices hospitals face in making capital expenditures have increased less than 2 percent a year since 1987, while capital spending has increased about 10 percent a year. This means that a large portion of the capital cost increases is due to purchasing more or more expensive capital assets.

Same Payment Incentives

Because payments for operating costs are under the DRG system and capital payments remain on a cost basis, hospitals have incentives to substitute capital costs for operating costs even if this is not the best overall management decision. This is because Medicare capital payments increase in proportion to capital cost increases while operating cost increases no longer result in operating payment Increases. We have limited evidence that hospitals did, indeed, spend more on capital during the early years of PPS than they would have if total hospital payments had been based on costs. The incentive to inappropriately substitute capital for operating resources is a compelling reason for reconsidering the current capital payment system.

In addition, the current dual payment system creates an artificial distinction between capital and operating resources. Hospitals consider both capital and operating costs when making an investment decision. Therefore, Medicare should provide one payment system with a consistent set of financial incentives rather than maintain two different payment systems.

Fairness of Current System

The current payment method also does not treat all hospitals fairly. Under cost-based reimbursement, if a hospital spends more on capital investments, it receives more in Medicare payments. This is true whether the capital investment is needed and will be used efficiently or not.

In addition, the current capital payment discount of 15 percent is applied to all hospitals and all capital costs. While this discount may impose a certain amount of discipline on hospital capital spending, it does so without any rewards for efficient hospitals. Both high spending and low spending, as well as efficient and inefficient, hospitals are subject to the same payment reduction.

APPROPRIATE PAYMENT METHOD

As I indicated earlier, Mr. Chairman, the Commission is concerned about the appropriateness of a prospective, per-case capital payment system. Our concerns are related to the significant variations in capital costs among hospitals, which are only partially explained by factors such as the mix of cases, geographic location, and type of hospital. Also, because hospitals tend to make major capital investments only on a periodic basis, their investment cycle is far from smooth. Further, the costs associated with these investments can often extend over 10 to 30 years.

I would like to briefly describe some of the factors that we have found to be associated with variations in capital costs and the components of a payment system that should be included to address them.

Capital Cost Variation

Capital costs vary widely across hospitals. The average hospital had a Medicare inpatient capital cost per case of $449 in the fifth year of PPS. Ten percent of hospitals, however, had Medicare inpatient capital costs below $ 155 per case and another ten percent had costs above $827 per case (see Table 2). Characteristics such as teaching commitment, location, and size do not explain much of this variation.

In general, urban, teaching, and larger facilities have higher per-case capital costs. Urban disproportionate share hospitals tend to have higher costs than nondisproportionate share hospitals. Proprietary hospitals tend to have higher costs than other ownership groups. Facilities in more urbanized areas tend to have higher capital costs per case. Particular regions of the country, such as the Pacific, South Atlantic, and Middle Atlantic regions, also tend to have higher than average capital costs. Within any of these hospital groups, however, significant variation remains.

We know that age of assets and proportion of debt financing explain some of this variation. Newer hospitals with newer assets have higher costs. Hospitals that use more debt to finance capital purchases also have higher costs. Location, scope, and scale of services also explain some variation in capital costs.

The adjustments for case mix, geographic cost differences, disproportionate share status, and outlier cases with long lengths of stay or especially high costs that the Secretary has incorporated in his proposal help to account for appropriate variations in capital costs, but still leave some of the variation unexplained. Therefore, other payment adjustments are likely to be necessary to assure that the Medicare program adequately compensates hospitals for variations in costs that are beyond their control or that are important in maintaining beneficiary access and high quality services. We will continue to study this issue to recommend further adjustments and refinements as necessary.

Capital Cost Cycle

Most hospitals retire and replace some capital assets every year, but major capital projects are undertaken infrequently. It is not possible to predict when any given hospital is likely to renovate or replace existing assets or acquire additional capital assets because many factors affect the timing of investments. Some hospitals, because of their overall financial status and other factors, are in a better position to make more frequent major investments than others. Other hospitals may have to postpone capital projects to save enough to make the investment or forego the project altogether. All facilities have at least some flexibility in the scope and timing of major investments.

Table 2.—MEDICARE INPATIENT CAPITAL COST PER CASE, PPS 5-HOSPITAL WEIGHTED VALUES

Hospital group	Percentile				
	10th	25th	50th	75th	90th
All hospitals	$155	$231	$363	$573	$827
Urban	234	332	487	691	975
Rural	129	177	254	391	556
Large urban	256	363	546	763	1,041
Other urban	218	302	445	629	872
Rural referral	215	258	390	505	657
Sole community	140	197	270	430	542
Other rural	121	167	239	346	519
Major teaching	319	418	597	763	1,094
Other teaching	256	351	485	663	893
Non-teaching	144	210	321	524	773
Disproportionate share:					
Large urban	295	407	590	822	1,106
Other urban	248	344	478	657	886
Rural	110	159	252	394	568
Non-disproportionate share	149	216	326	524	758
Urban <100 beds	168	236	358	586	933
Urban 100-199 beds	242	352	526	773	1,142
Urban 200-299 beds	275	363	514	700	955

Table 2.—MEDICARE INPATIENT CAPITAL COST PER CASE, PPS 5-HOSPITAL WEIGHTED VALUES—Continued

Hospital group	Percentile				
	10th	25th	50th	75th	90th
Urban 300-399 beds	282	372	510	673	896
Urban 400-499 beds	291	373	518	666	871
Urban 500+ beds	327	422	558	720	924
Rural <50 beds	107	149	211	294	448
Rural 50-99 beds	138	187	273	404	577
Rural 100-149 beds	176	241	328	469	714
Rural 150-200 beds	196	240	347	468	633
Rural 200+ beds	211	252	351	510	616
New England	163	224	306	443	605
Middle Atlantic	176	264	402	596	844
South Atlantic	166	255	409	611	878
East North Central	189	249	356	526	712
West South Central	123	192	330	552	781
West North Central	131	182	261	429	630
West South Central	140	222	396	667	1,022
Mountain	135	220	338	579	846
Pacific	217	332	484	705	1,004
Voluntary	174	252	391	575	789
Proprietary	162	261	477	767	1,120
Urban government	175	251	373	554	731
Rural government	118	162	235	331	486

SOURCE: ProPAC analysis of Medicare Cost Report data.

The Secretary, through the two transition methods and exceptions policy, attempts to recognize the periodic nature of major investments. The Commission believes that, through these mechanisms, the proposed capital payment system, with the modifications we are suggesting, provides adequate protection for historic investment decisions. The Commission remains concerned, however, that new capital investments may remain vulnerable to this change in payment policy. We believe, therefore, that there should be a permanent exceptions process, which I will describe shortly.

SECRETARY'S PROPOSAL

As stated earlier, ProPAC unanimously agreed to accept the Secretary's approach, contingent on a number of modifications. These modifications are designed to address our concerns regarding the significant variation in capital costs across hospitals and the need to provide adequate protection for appropriate new investments. Our suggested changes also reflect our belief that Medicare should provide a single payment system for operating and capital costs with a consistent set of financial incentives rather than maintain two different payment systems. Medicare's hospital payments should recognize that hospital managers should make investment decisions based on the overall financial well being of the institution, not just Medicare's capital cost payment formula.

Before describing our recommendations, Mr. Chairman, it is important to note that two specific features of the Secretary's proposal are estimated based on an actuarial model of 6000 hypothetical hospitals. HCFA needed to rely on a modeling approach because data were not available on changes in hospital assets over time and specifically, the decline in existing assets and acquisition of new assets. Thus, the model was needed to calculate the budget neutrality adjustment and the reduction factor for expected exceptions payments.

The Commission has been concerned that details of this modeling effort were not available in the proposed rule. Others, notably the AHA, have claimed that HCFA's estimates of the budget neutrality adjustment and exceptions reduction factor were significantly different from their own estimates. ProPAC has been working with HCFA and the to understand the differences in the modeling efforts and whether HCFA should modify their model to more accurately reflect hospital behavior. HCFA staff have been cooperative in helping us understand the use of and assumptions behind the model. When we have completed our analysis, ProPAC will report

our views of HCFA's approach to this Committee and the Committee on Ways and Means.

Now I would like to briefly describe our recommended changes to the proposed regulation. We plan to monitor the implementation of this system for any adverse effects on hospitals or Medicare beneficiaries and to recommend future changes as necessary. As I mentioned earlier, more detailed information on these recommendations is contained in our May 15 report.

Federal Rate

We believe that the 1992 Federal rate that was in the proposed rule was too low because it was based on assumptions of low growth in capital costs from 1988 through 1991 and large increases in Medicare admissions. These assumptions do not reflect recent experience. We know that HCFA is recalculating this rate based on more recent data. We will be examining their latest cost and admission assumptions and report back to this Committee with our assessment of the Federal rate that will be incorporated in the final rule.

ProPAC believes that it is critical that this rate be based on realistic assumptions about capital cost increases and Medicare admissions. Even though only a small portion of capital payments will be based on the Federal rate in 1992, this is an important element of the prospective payment system for capital. Over the transition period, a growing share of payments will be based on this updated Federal rate and after the transition, Medicare's capital payments will be based entirely on this per-case amount.

Payment Adjustments

In general, the Commission believes that the prospective payment system for capital should be consistent with the system currently in place for operating costs. To this end, we believe that the payment adjustments currently applied to operating payments should be applied to capital payments. In the longer term, the level of these adjustments should be recomputed based on data on total Medicare costs—combining capital and operating costs. Our recommendations on the specific payment adjustments reflect our overall philosophy that prospective payment for capital should end the arbitrary distinction between capital and operating payments.

More specifically, we support the application of the same relative DRG weights to capital and operating costs. The Commission continues to believe, however, that cost-based weights would be more appropriate than charge-based weights for both capital and operating payments.

We support the short-term use of the area wage index to adjust for geographic variation in capital costs. We recognize, however, the need for further research on more appropriate measures of geographic capital price variation.

We agree that it is appropriate to apply a disproportionate share adjustment to capital payments. However, the application of the DSH adjustment should be modified from the proposed rule to apply to all hospitals that receive DSH payments for operating costs. The proposed rule did not allow small urban and rural hospitals to receive disproportionate share payments. Yet, for policy reasons, these hospitals have been able to qualify for disproportionate share operating payments. The same reasoning should apply to capital payments as well.

Similarly, even though the Secretary did not propose a teaching adjustment, the Commission believes that there should be a teaching adjustment to capital payments. We recognize that in the longer term the level of this adjustment may need to be adjusted based on an examination of capital plus operating costs.

The final payment adjustment included in the proposal was for outlier cases. We support the method the Secretary chose to recognize the added costs associated with outlier cases. In the longer term, we believe further research is needed to establish combined capital and operating marginal cost factors and to consider if capital outlier payments may be more appropriately applied to the institution rather than the case.

Transition

The two proposed transition methods—one for high capital cost hospitals and another for low capital cost hospitals—are important in addressing our concerns about moving to a prospective per-case payment system for capital. Expanding the definition of old capital under the hold harmless method, however, is necessary to improve the protection this transition mechanism provides. The definition should be expanded in two ways. First, old capital costs should include all capital costs on a hospital's 1990 cost report, not just depreciation and interest. Second, the definition of old capital costs should recognize that hospitals can make significant financial commitments several years before the capital costs are recorded on the Medicare

cost report. The costs associated with projects initiated on or before the hospital's cost reporting period ending in fiscal year 1990 should be recognized as old capital costs.

Exceptions

The long-term nature of capital costs and the cyclical nature of these costs should be addressed with the exceptions process. Further, because of the characteristics of hospital capital costs, the exceptions process should continue beyond the transition period. In addition, the Secretary should develop criteria to allow hospitals facing special circumstances to receive exceptions payments. We are particularly concerned about two types of hospitals. First, those hospitals that will need to undertake a major capital investment during the early years of the transition may have a particularly difficult time covering their added costs. Second, there will be some hospitals that will never be able to accumulate enough funds to engage in needed renovations or replacements. The exceptions process should be designed to help these hospitals.

The Secretary recognized the special needs of rural sole community hospitals and urban disproportionate share hospitals by allowing them to receive exceptions payments at a lower payment threshold. These hospitals, however, should not be required to offset their exceptions payments with positive operating margins. The Commission believes that the offset provision is inconsistent with Congressional intent, which provides for extra operating payments to assist these hospitals. Therefore, they should continue to be subject to the more lenient exceptions process, but without the payment offset.

Updates

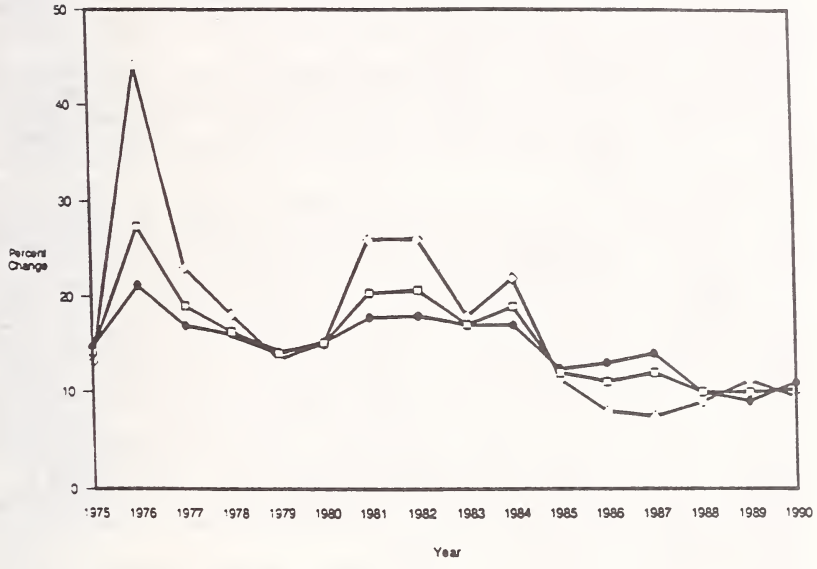
Finally, Mr. Chairman, the Commission believes the Secretary should change the proposed method for updating the capital payment rates. Instead of basing updates between now and 1995 on prior years' capital cost increases, these updates should be based on a formula similar to the method used to develop an update for the PPS rates. The Secretary should develop this methodology to use in setting the 1993 rates. We believe that the ultimate goal of this payment approach should be to apply a single update factor to both capital and operating costs.

CONCLUSION

In conclusion, Mr. Chairman, the Commission was pleased with the response of the Secretary to the concerns of the hospital industry in drafting this payment proposal. We believe that our recommended changes will further improve the proposed capital payment system.

We will be happy to work with you and the Secretary in improving the proposed system. We are now working with HCFA staff on the actuarial model and the 1992 Federal rate. We will report back to you on our analysis of these issues. And, as I said earlier, the Commission will continue to monitor the implementation of this new payment method and recommend additional modifications as necessary.

Figure 1. Change in Capital Costs: Depreciation, Interest, and Total Capital, 1975-1990 (In Percent)



SOURCE: American Hospital Association National Hospital Panel Survey

RESPONSES OF STUART H. ALTMAN TO QUESTIONS SUBMITTED BY SENATOR ROCKEFELLER

Mr. Rockefeller. Given ProPAC's support of HCFA's proposed regulation for hospital capital but with some serious reservations, would ProPAC support a payment floor—meaning no hospital could receive less than a certain percentage of costs? If so, should a payment floor be permanent?

Mr. Altman. The Secretary's capital payment proposal would make capital and operating payment incentives consistent. Thus, hospitals would have stronger incentives to evaluate together the operating and capital costs associated with any project. The Commission strongly supports promoting this type of hospital behavior. A payment floor would dampen these incentives by assuring hospitals a minimum level of capital payments.

The Commission recognizes, however, that prospective payment for capital could have an undue adverse impact on certain hospitals. That is why we support the 10 year transition to fully prospective rates. Within this period most hospitals should be able to modify their capital investment behavior to the payment incentives.

The exceptions policy also acts as a floor, protecting hospitals with major capital commitments. ProPAC has recommended that the Secretary should modify the exceptions payment provision to include a permanent exceptions process. Also, rural sole community and large urban disproportionate share hospitals, which are subject to more lenient exceptions thresholds, should not have to offset their exceptions payments with any positive operating margins. Finally, the Secretary should develop exceptions criteria to allow hospitals facing special circumstances to quantify for exceptions payments. These special circumstances would include those that need to undertake a major capital investment during the early years of the transition and those that will never be able to save enough to finance a major capital project.

Mr. Rockefeller. How could a hospital with capital costs per case *above average* modify its capital spending behavior to keep its capital expenses in line with what Medicare would pay under HCFA's proposal?

For example, West Virginia University recently completed construction of a new hospital. Their capital costs are 3 times the national average. How will WVU manage—especially after the 10 year transition?

Mr. Altman. A prospective capital payment approach provides incentives for hospitals to manage total Medicare costs. Therefore, any given hospital should evaluate total costs per case in relation to total Medicare payments per case. Thus, hospitals could decide that, given their particular situation, it is appropriate to make a capital expenditure even if this would raise their capital costs above the national average. It is also likely that hospitals with above average capital spending will be able to control future spending because they will have less need for renovation and new equipment.

Previously hospitals had incentives to favor capital over other expenditures because of Medicare's payment system. They will need some time to adjust to the new capital payment incentives. We believe that a 10 year transition period will be adequate for most. For those with special needs, the exceptions process, which we believe should be expanded as described above, should be adequate.

Finally, the payment adjustments are designed to provide payments to hospitals for factors that influence their costs that are beyond their control or that the Medicare program is obligated to support. To this end, ProPAC has recommended that the payment adjustments applied to capital payments be the same as those applied to operating costs. This would include the addition of a teaching adjustment. This could be particularly helpful to an institution like the West Virginia University Hospital.

Mr. Rockefeller. What impact do you think there will be on other payers if Medicare folds capital into PPS? How do private payers currently pay their "share" of capital? Could other payers, such as Medicaid agencies or BC/BS adopt a similar approach?

Mr. Altman. To the extent that Medicare's prospective payment system for capital is successful in modifying hospital capital investment behavior, other payers will directly benefit through lower costs. When hospitals were paid prospectively for Medicare's operating cost but on a cost basis for capital, hospitals had incentives to over invest in capital. This raised costs for all payers. A combined payment approach provides consistent incentives through Medicare for hospitals to control the total costs of providing care to Medicare beneficiaries.

To the extent that hospitals will be reimbursed for less than their capital costs under the new payment method, pressure to recoup these costs from other payers will be increased. The Medicare program, however, is obligated to pay a fair rate to

hospitals for their capital costs. We believe the Secretary's proposal does that. Further, in establishing that fair rate, the Medicare program should not be directly influenced by other payers. ProPAC recognizes, however, that uncovered costs are becoming a growing problem in hospitals.

It is unlikely that private insurers or BC/BS plans would adopt a capital payment approach similar to that in the proposed rule. This is because few other payers separated capital payment in the first place. Payers base payments on charges or negotiated rates, which include capital costs. Many Medicaid programs, on the other hand, pay separately for capital costs. Some of these programs may adopt Medicare's new payment approach.

Mr. Rockefeller. In the long run, what do you think the impact of folding capital into PPS will have on rural hospitals? Do you think rural hospitals will be able to somehow "save" for future capital projects?

Mr. Altman. The proposed payment system is based on average Medicare inpatient capital cost per case. Most rural hospitals, therefore, will receive higher capital payments because their capital costs are significantly below the average. The ability of rural hospitals to save these excess capital payments for future capital projects, however, depends more on their overall financial condition than how much they will be paid for capital costs. If a hospital is not covering its operating expenses, the extra capital payments will probably be used to offset operating losses. Further, capital costs typically represent less than 10 percent of total hospital costs. Therefore, even if a rural hospital is receiving capital payments significantly more than their actual costs the capital payments may not significantly change their financial picture.

The proposed capital payment method is volume driven. As such, hospitals receive a per case payment when they treat a Medicare beneficiary. Previously, Medicare capital payments were based on Medicare's share of the hospital's total capital costs. To the extent that rural hospitals continue to lose volume, they will eventually receive capital payments less than their capital costs under this payment approach.

Prepared Statement of Senator Lloyd Bentsen

Mr. Chairman, finding an appropriate method for payment of hospital capital costs under the Medicare program has been an issue ever since we enacted the Prospective Payment System for payment of operating costs in 1983.

The Health Care Financing Administration (HCFA) was given the task of designing a means of moving from the cost-based system we have in place, to a prospective, per-case payment system for Medicare hospital capital costs. The challenge is to do so in a manner that avoids unfairly penalizing hospitals either for capital spending commitments previously made or for postponing needed improvements in an effort to be prudent purchasers. We all recall that past capital payment proposals failed due to criticism that these concerns were not sufficiently addressed.

Since HCFA published its proposal in late February, the Prospective Payment Assessment Commission, hospital associations, and individual hospitals have been working to understand its likely impact and have proposed modifications. Mr. Chairman, a variety of perspectives are represented at this hearing. I want to join you in welcoming today's witnesses, particularly the two Texans, Dr. Dalston from Houston's Hermann Hospital, one of the leading teaching facilities in Texas; and Judith Smith from Daughters of Charity Health Services in Austin, which includes Seton Medical Center, a community hospital important to the growing Austin area population. I look forward to their testimony and that of all the witnesses.

Prepared Statement of Michael D. Bromberg

Mr. Chairman and Members of the Committee, my name is Michael D. Bromberg and I am Executive Director of the Federation of American Health Systems, the national association which represents investor-owned health systems. Our members include more than 1,400 hospitals, as well as integrated health plans which insure several million Americans. Our member hospital management companies also manage under contract more than 300 hospitals owned by others.

We appreciate the invitation to appear before the Committee to present our views on the proposed rule published by the Health Care Financing Administration (HCFA) on February 28, 1991, concerning a new prospective payment system for inpatient hospital capital-related costs.

BACKGROUND

Capital expenses among Medicare participating hospitals for the past four years has remained relatively constant as a percentage of operating expenses. This trend demonstrates that the statutory percentage limitations on capital cost reimbursement have served to control capital costs. Furthermore, because the increase in DRG payments has lagged well behind the increase in the costs of treating Medicare patients, average margins have become negative and capital investment has slowed down. The rate of increase in Medicare capital payments per case has slowed dramatically. Capital payments per case rose at a compound annual rate of 15.8% from 1984–1987. During the period 1987–1990, the growth slowed to an average of 7.9%. In 1990, the Medicare capital payment per case increase was 5.8%. These numbers do not reflect the Congressionally mandated percent reductions in capital payments.

Thus, we question the need for a new payment system at this time. In any event, the proposed regulations will not achieve additional budget savings, but simply will redistribute capital payments among hospitals. For example, in the first year of the transition, the proposed capital payment system will result in massive redistribution of capital payments from hospitals above the national average capital cost (a 6.5 percent reduction) to those hospitals below the national average (a 43 percent increase). We believe this redistribution will continue to a significant degree throughout the transition. No satisfactory rationale has been presented to justify such redistribution.

We believe that folding capital into the DRG prospective payment system will have little or no effect on behavior. The average hospital with forty percent Medicare days receives thirty percent of its revenues from Medicare. Only ten percent of that thirty percent is for capital reimbursement. Altering the method of payment which covers three percent of revenues will not change *overall* behavior very much. However, individual hospitals could be very adversely and arbitrarily affected if they have just completed or are about to complete a major capital project and are insufficiently protected under the proposed regulation.

Capital decisions for the average hospital are based on *total* payments and *overall* margins, not one line item in a cost report. Operating losses have already restrained capital so we view this regulation as overkill.

SPECIFIC PROBLEMS WITH THE PROPOSED CAPITAL REGULATION

Dr. Gail Wilensky, Administrator of HCFA, and her staff have done an outstanding job in outlining the basis for a capital prospective payment system. However, we believe the details of the proposal fall far short of achieving HCFA's stated objectives.

Predictability of Payments

The proposed capital payment regulation does not provide the predictability of capital payments that is critical to the hospital industry. The predictability of reimbursement is supposed to be one of the most beneficial aspects of a prospective payment system. However, the rule proposed by the Health Care Financing Administration (HCFA) does not achieve this result. For example, HCFA has not published the projected federal capital payment rate for the ten year transition period, nor has it made available all of the projected adjustment factors. Despite our Freedom of Information Act request, this information has never been provided in a readily available format. It has not been possible to determine the individual adjustment factors (i.e. budget neutrality, the size of the exception pool) to the projected Federal rate even after the release of HCFA's model. The impact of the regulation on individual institutions is difficult, if not impossible, to predict beyond the first year of the regulation because the annual update for the Federal rate is unknown beyond 1995, and the budget neutral adjustments are unpredictable. Additionally, the Congressional budget process itself could produce categorical sequesters over which hospitals have no control, thus further limiting the predictability of the new capital payment system.

Definition of Old Capital Costs

While we applaud HCFA's intent to hold harmless capital costs obligated prior to this regulation, the proposed definition of old capital costs provides inadequate protection to hospitals with relatively high capital cost obligations because it fails to recognize the long term nature of certain allowable capital costs. Among the most important of these are leases, property taxes and capital costs of related organizations. While HCFA estimates that these currently allowable capital cost items account for between 15-20 percent of total inpatient capital costs, they represent a much higher percentage of capital costs for many hospitals.

Regarding leases, some hospitals lease the majority of their movable equipment. Moreover, many hospitals lease their entire property and plant as well as equipment. Lease commitments are binding, and the lease or rental costs are equivalent to the depreciation and interest expenses recognized under the proposed definition of old capital. Leases have become a major financing vehicle in the past few years and as such may be underestimated in HCFA data from 1988 cost reports. Lease and rent payments alone may account for more than 10 to 20 percent of total capital costs for some hospitals. Thus failure to recognize these payments renders the hold harmless payment methodology useless to these hospitals.

For example, Hospital A has $2,000 per case in old capital and about 30 percent or $600 of that amount represents leasing costs. The regulation would grandfather only 90 percent of the $1,400 because the leasing costs are not included. If the hospital went instead under the ten-year transition it would receive 90 percent of its hospital specific capital costs or $1,800 for the first year, $1,600 for the second year and $1,400 for the third year since leases are included in the hospital specific portion of the transition rate.

It is also important that HCFA recognize short-term leases that may be renewed during the transition period as long as the asset remains in service. Similarly, hospitals have used short term debt to finance capital assets, Generally, hospitals intend to extend or roll-over debt when it becomes due, preferably at a more favorable interest rate. Such debt should be included in the definition of old capital when it is used to finance existing capital expenses.

Property taxes represent about 10 percent of investor-owned hospital capital cost reimbursement but would not be included in the definition of old capital. Thus the above example where neither leasing costs nor property taxes are recognized for the hold harmless provision, the consequences would be even more detrimental for an investor-owned hospital.

Obligated Capital Expenses As Old Capital

The proposed definition of old capital costs does not account for capital-related expenditures which a hospital is legally obligated to pay if the assets were not yet in use by the close of the latest cost reporting period ending on or before September 30, 1990. For example, Hospital B approved a major renovation or new hospital or major equipment purchase in late 1989 or early 1990 but the facility did not open or use the equipment until after the cost reporting periods ending in fiscal 1990. The facility spent a million dollars or more toward the project. The proposed regulation does not allow this project to be considered a grandfathered obligation.

The stated purpose of the hold harmless payment methodology is to recognize and compensate hospitals for binding capital asset commitments made prior to the implementation of the capital payment regulations. Therefore, using tax transition rule precedents as a model, these types of capital obligations should qualify for hold harmless treatment if this provision is to be equitable.

Property Taxes Adjustment

In addition to recognizing property taxes under the hold harmless provision, the regulation should also pass through or prospectively adjust for property taxes under the Federal rate. Since property taxes are imposed by State and local governments, they cannot be avoided or reduced through efficiencies or economies imposed by the hospital. Property taxes account for approximately 10 percent of the capital related costs for investor-owned hospitals, based on the data provided in the preamble to the proposed regulations. These costs are currently recognized by the Medicare capital reimbursement system. Absent an adjustment to the Federal rate, investor-owned hospitals will sustain a significant and disproportionate drop in payments.

Undate Factor

The proposed rule provides that the update factor would be based on an actuarial estimate of the increase in Medicare inpatient capital costs per discharge, adjusted for case mix change.

HCFA has not provided the statistical documentation relied upon in the determination of the update factors for FY 1989–1992. The components utilized in the determination of the update factor, as well as the detailed computation of the factor, should be provided for review by the public as to its accuracy, not only for the fiscal years mentioned, but for all future fiscal years as well.

It is imperative that the update factor not be used as a budgetary tool in subsequent years to reduce total payments for Medicare. The actuarily determined update factor should be applied at 100% to increase Medicare payments for inpatient capital costs so that payments are equal to the hospital industry's actual marketplace capital cost increases.

New Capital Payment Floor

Our final recommendation is most important because it goes to the heart of our concerns about this proposed regulation and our unfortunate but justified mistrust of the budget driven regulatory system we have come to know so well over the past decade.

The Health Care Financing Administration has certainly listened to our concerns and has promised in general terms to issue a final regulation which addresses most of those concerns discussed in our testimony. We will certainly be looking for those improvements in the language of the final regulation, but even if that is the case, there are a significant number of hospitals subject to abnormal risk of underpayment for needed future capital expenditures.

The impact of the proposed regulation on individual institutions is difficult, if not impossible, to predict beyond the first year or two of the regulation. Among the reasons: (1) HCFA has not been willing to share its model; (2) the annual update factor is unknown beyond 1995; (3) the budget neutral adjustments are unpredictable; and (4) the budget process itself may produce categorical sequesters over which hospitals have no control.

Based on our past experience we do know that hospitals have lost faith in the objectivity of the budget process and that many Members of Congress share our view that Medicare cuts have been proposed and enacted as an arbitrary way to reduce Federal deficits without regard for policy.

From a policy viewpoint we would hope that Congress wants to monitor this capital regulation very closely to protect against geographic (potential shift of capital dollars from one part of the country to another due to differences in future capital needs) and other inequities which could arise from application of a complex regulation like this one. While Congress can always monitor the effect of any government regulation through its oversight powers, this regulation is so complex and its potential for underpayment of hospitals' capital expenses so severe that Congress should build into the final regulation some limits on the adverse impact which might result during the transition period.

The proposed ten year transition period itself is an admission that some minimum payment level is needed to guard against severe damage to some hospitals. The problem is that the transition period recognizes only base year costs rather than actual costs each year so the prospect for severe financial harm to some hospitals remains a distinct possibility. In addition, the exception process is inadequate because for most hospitals it only applies to costs above 150 percent of the national rate.

There is one change in the regulation which would assure Congress the time to monitor the impact and which affords minimum protection to hospitals while still allowing HCFA to go forward with a final regulation. That change would be the addition of a payment floor so that notwithstanding any other provision of the regulation, no hospital would receive less than its actual costs minus a discount such as 20 percent. Congress could review the economic impact of the regulation at any time and change this floor if such a change is justified.

In order to maintain budget neutrality we would recommend that a payment floor be financed by a combination of sources, not just one source, including a reduction in the size of the exceptions and outlier pools and a limitation on the excess of capital payments over actual costs for those facilities whose actual capital spending is substantially below the national payment rate.

We believe this regulation is so complex and that its impact is so difficult to gauge that a payment floor is the only way to assure fairness and provide time for Congress to monitor this new payment system.

Thank you for your consideration of our comments on this important subject.

PREPARED STATEMENT BY SENATOR JOHN H. CHAFEE

Mr. Chairman, I commend you for convening today's hearing on Medicare capital payment policy. I also commend Dr. Wilensky and her staff for the Herculean task they have accomplished in developing the proposed regulations. I know that it was a thankless task, and that it will continue to be difficult as you seek to refine the regulations.

For a number of years we have struggled over the issue of reimbursement for capital related costs under the Medicare program. During that time, I have been in the unique position of representing a State which has one of the most stringent health planning requirements in the nation. Rhode Island utilizes a Certificate of Need process that determines both a project's medical necessity and affordability within

an aggregate upper limit on Statewide capital payment growth. In other words, a Statewide cap on capital expenditures. As a result, Rhode Island has what may be the oldest hospitals in the country.

For a number of years, the Hospital Association of Rhode Island has advocated folding hospital payments for capital related costs into Medicare's prospective payment system. They have asserted that by incorporating capital reimbursement into PPS, they would be in a better position to make long term plans for new capital expenditures. They have, with a few reservations and recommendations, expressed support for the proposed regulations.

I thank Dr. Wilensky for her efforts and look forward to working with her to help address the needs of hospitals and in working toward implementation of the regulations.

PREPARED STATEMENT OF JEPTHA W. DALSTON

Mr. Chairman, it is an honor to be invited to testify before the Senate Finance Committee on the issue of Medicare capital payment policy. I am Jeptha W. Dalston, Ph.D., President and Chief executive Officer of Hermann Hospital. Hermann is a member of the AAMC Council of Teaching Hospitals, and I appear today on behalf of Hermann Hospital and its trustees as well as the nation's major tertiary care/teaching hospitals. Before I outline the AAMC's position on Medicare capital payment policy, I would like to discuss the impact of the proposed capital regulation on Hermann Hospital.

Hermann Hospital, located in Houston, Texas, is the major teaching hospital affiliated with the University of Texas Health Sciences Center at Houston. Using the Health Care Financing Administration's (HCFA) capital payment model, Hermann calculates that under the proposed regulation it will lose $2.5 million in Medicare payments during the first 5 years of the proposed regulation's implementation. This loss reflects capital costs for existing capital and does not include the completion of a new capital replacement project. The more important issue, however, is the $8.2 million loss which Hermann will experience as it proceeds with the mandated hospital replacement project. Hermann Hospital urges the Senate Finance Committee to consider the equity of HCFA's proposed capital regulation because it unfairly penalizes an institution that:

- provides $3.2 million in uncompensated care last year based upon the costs of the care, with 26.3 percent of its total patient population having no payment resources or being Medicaid patients. For my purposes here today, the $31.2 million includes patients with no resources and Medicaid contractual deductions;
- maintains an occupancy level close to 80 percent of total capacity, with 15 percent Medicare inpatient discharges;
- treats a sicker than average population of Medicare patients, with a case mix index of 1.60;
- furnishes health care services to 8800 Medicaid inpatients annually, accounting for 20 percent of Hermann's patient population, and is one of the ten largest Medicaid providers in the State of Texas;
- participates in the Medicare program as a disproportionate share hospital with a 39 percent disproportionate share factor;
- trains over 300 residents; and,
- provides an environment for biomedical research.

These characteristics constitute the type of hospital that bears the greatest burden of this proposed regulatory change. High occupancy, the provision of extensive community service, and quality medical education should not be the characteristics of the hospitals penalized. While the regulatory initiative is intended to eliminate excess capacity and may drive some hospitals out of existence, this hospital and others like it are not the proper targets.

Each hospital's capital structure is unique based upon its history and the changing demands of its services. Capital expenses change from year to year. Hermann is moving from a ten year period of relatively low capital expenditure to a period of increased capital expenditure beginning in 1992. The extent of change in capital costs for Hermann is not addressed by HCFA's proposed capital payment formula. Hermann's plant and equipment have been depreciated almost 50 percent. For the past 5 years Hermann has been planning a $100,000,000 major renovation project to replace a 40 year old structure which does not meet Federal and State health and safety codes as well as the Joint Commission on Accreditation on Health Organizations' requirements.

Replacing an antiquated pavilion will require more than $100,000,000 in capital expenditures over the three year period, 1992–1994. As a result of this needed replacement facility, Hermann will experience a 50 percent increase in its total plant and equipment base. However, under the HCFA proposed formula, Hermann capital payments are determined using the "hold harmless" provisions. By year 6, the "hold harmless" methodology will result in capital payments based 100% on the Federal rate with no recognition of actual hospital costs. Thus, the "hold harmless" methodology provides

Hermann Hospital with less revenue than the hospital-specific/federal blend alternative. The chart attached to this testimony demonstrates the impact of this point in dramatic fashion. Consequently, Hermann Hospital believes that the "hold harmless" approach should not be mandatory. See attached chart. Hospitals should be given the option of either the blended transition rate or the "hold harmless" rate.

As of April 30, 1991, $200,000 has been spent on out-of-pocket costs associated with the major replacement program. These costs are attributed primarily to architectural fees. Hermann's capital project is expected to be completed in 1994. Therefore, although Hermann has a significant capital project underway, it will not be recognized as old capital under the proposed regulation. Thus, the new facility will increase the capital payment deficit for Hermann Hospital.

The facts above briefly describe the situation of Hermann Hospital and the adverse consequences of HCFA's proposed capital payment regulations. The AAMC recommendations for modifying the HCFA proposal will help teaching hospitals, including Hermann Hospital, continue to meet their capital obligations. While the Association is opposed to payment for Medicare inpatient capital costs on other than a cost basis, the AAMC acknowledges that OBRA 1987 requires capital payments to be folded into the Medicare prospective payment system (PPS). The AAMC is concerned that the HCFA's proposal does not adequately consider existing variation in capital costs both within and among groups of hospitals. Despite extensive analyses by the Prospective Payment Assessment Commission (ProPAC) and others, much of the variation remains unexplained. In its May 15, 1991 report to Congress, "Medicare's Capital Payment Policy," the Commission notes that:

> . . . because of the periodic nature of capital investments and other factors, including use of debt financing and scope and scale of services, capital costs vary widely across hospitals. Urban, teaching, and large bed size hospitals, for example, tend to have higher than average capital costs. However, the capital cost variation within these groups of hospitals is almost as great as the variation among these groups. All of these factors contribute to the difficulty of developing a prospective, per case capital payment system, based on average costs, that would not be too disruptive to the hospital industry. (Executive Summary p.1.)

A Medicare prospective payment system for capital is insensitive to a hospital's capital cycle and disconnects capital payments from the actual cost of acquiring capital. If capital is incorporated into PPS, hospitals will essentially change from operating under a capital recovery policy (reimbursement) to a capital formation policy, where the hospital would be required to save money to invest in capital. Prospective payments for capital may be detrimental to those hospitals with old physical plants that may receive more funds under the Federal rate, but will be unable to save enough funds to update their plant. Prospective payments to hospitals with new physical plants may be less than the hospitals' debt services. These hospitals would have to borrow against future payments to cover initial shortfalls in capital payments, causing these institutions difficulties in saving for future capital projects.

Should the Congress choose to allow the HCFA to incorporate capital into PPS, the AAMC believes five major deficiencies in the HCFA's proposal should be corrected in the final rule:

I. Include an indirect medical education (IME) adjustment for capital costs;
II. Recognize the higher capital costs per case for urban hospitals compared to rural hospitals;
III. Extend the exceptions policy beyond the transition period;
IV. Expand the narrow definition of "old capital;" and,
V. Establish a permanent payment floor.

Each of these recommendations is described below. Additionally, this testimony addresses several other aspects of the proposed rule, including the inadequacy of the updates used to adjust hospital capital costs from 1988 to 1992, and burdensome recordkeeping requirements.

I. THE NECESSITY OF AN INDIRECT MEDICAL EDUCATION ADJUSTMENT

The AAMC strongly recommends that the Congress and the HCFA include an indirect medical education (IME) adjustment in the prospective payment system for inpatient hospital capital-related costs.

The AAMC represents over 350 of the nation's major teaching hospitals participating in the Medicare program. These hospitals provide inpatient services to 19 percent of all hospitalized Medicare beneficiaries, and 29 percent of Medicare beneficiaries in the 25 DRG classifications with the highest weights. Major teaching hospitals have a three-pronged mission including comprehensive patient care, education of health professionals, and provision of an environment for biomedical research. Their unique social mission causes them to have substantially different capital requirements than non-teaching hospitals. Sixty percent of the non-federal members of the AAMC's Council of Teaching Hospitals (COTH) operate trauma centers, compared to only 12 percent of all other hospitals. Similarly, 55 percent of non-federal COTH members provide organ and tissue transplant services compared to only 9 percent of all United States' hospitals. Further, teaching hospitals are medically and technologically innovative and are responsible for introducing and establishing new and more effective diagnostic and treatment options. After evaluation in major medical centers, many of these innovations are adopted in other provider settings.

Since the inception of PPS, the Congress has consistently recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient operating payments to teaching hospitals with the IME adjustment. The IME adjustment should also apply to capital payments except for the inclusion of an IME adjustment, the HCFA's payment model for capital costs parallels the payment model for operating costs. The HCFA proposed capital methodology adjusts the Federal capital payment rate for hospital case mix, hospital wages, large urban area, and percentage of low income patients. These types of adjustments are also applied to those used for the HCFA's operating cost payments.

ProPAC's analysis of hospital capital costs shows that teaching hospitals tend to have higher Medicare inpatient capital costs. The higher capital costs reflect their widely-acknowledged role in the evaluation and early dissemination of new technology. It is neither logical, nor is it prudent public policy, to fail to recognize cost differences when they are associated with capital expenditures.

In its May 15, 1991 report to Congress, ProPAC accepted the HCFA's proposal subject to several modifications. The Commission recommends a payment system that eliminates the distinction between capital and operating payments to hospitals, applying the same payment adjustments to capital as operating payments, and including an IME adjustment paid at the current level. ProPAC further recommends that the disproportionate share adjustment (DSH) for capital costs be made identical to the operating DSH adjustment. Thus, all hospitals receiving IME and DSH payments under the operating cost PPS formula would also receive those adjustments to their capital costs.

The AAMC agrees with ProPAC that an IME adjustment at the same current policy level for operating payments should be made part of the PPS system for capital costs. Descriptive data presented by ProPAC show teaching hospitals have higher costs than other hospitals. (See **Medicare's Capital Payment Policy** p. 60) This recommendation is also supported by the following two major observations:

• The statistical analysis on which the HCFA based its decision to exclude an IME adjustment is flawed. The HCFA analysis results in a substantial understatement of the higher capital costs of teaching hospitals. The HCFA's proposal states that:

> we are not proposing to make an adjustment for the indirect costs of medical education because the results of all our capital regressions consistently indicated that the teaching variable was negative and statistically significant. All else being equal, teaching hospitals have lower capital costs than non-teaching hospitals. This indicates that the other variables more than account for the higher capital costs of teaching hospitals. (See 56 *Federal Register* at p. 8482, 8485.)

Yet in the final regression specification provided to the AAMC by the HCFA staff at an April 10, 1991 meeting, the coefficient on the measure of teaching level is positive, although not statistically significant. The AAMC believes that the coefficient on the teaching variable would remain positive and become significant (thereby showing that the capital costs of teaching hospitals are significantly higher than non-teaching hospitals) in properly specified regression models.

In conducting its analysis, the HCFA used different models to explain the variation in Medicare capital costs. Six variables included in the HCFA regression analyses are excluded from the payment model regression. The result of using an analytic approach which is inconsistent with the payment model is that capital costs of teaching hospitals are substantially understated. The positive and not statistically significant coefficient on the teaching variable was obtained in a regression specification including many variables that reflect the higher capital costs of major teaching hospitals in urban areas. These variables include three measures of the age of capital (calculated separately for fixed and movable assets), two measures of capital financing (the ratios of total liabilities to total assets, and current assets to total assets), and hospital occupancy. Including these variables in regression analyses reduces substantially the positive coefficients on the teaching level and urban variables.

• The HCFA's own simulations show that major teaching hospitals would be among the few groups of hospitals paid less than their actual capital costs. The HCFA projects that major teaching hospitals would receive 3.7 percent below their actual capital cost per case, or 4.5 percent below their standardized capital cost per case under the 100 percent adjusted Federal rate (Table 6, 56 *Federal Register* 8511). Major teaching hospitals are one of only four types of hospitals, among 23 types identified in the HCFA's analyses that show consistently negative results.

Hospitals will become "winners" or "losers" under the HCFA's capital payment system. Payment systems based on averages must include payment adjustments that account for differences in costs. To place major teaching hospitals among the "losers" is to put in jeopardy much of what those hospitals contribute to the health care delivery system. Where a hospital falls should reflect the strengths and weaknesses of its capital decisions, not the hospital's role in the health care system.

II. THE URBAN DIFFERENTIAL

The AAMC strongly recommends that the Congress and the HCFA increase the adjustment for urban hospitals from 1.6 percent to *at least* 6.9 percent.

In the Medicare operating PPS, the Congress has consistently recognized the higher costs of urban hospitals. The HCFA's own analysis indicates that urban hospitals' capital costs are 8.7 percent higher for hospitals located in large urban areas and 6.9 percent higher for hospitals located in other urban areas. However, the HCFA's proposed capital payment system provides an adjustment of only 1.6 percent for hospitals located in urban areas, significantly understating their substantially higher capital costs. The HCFA's proposed "urban" adjustment of 1.6 percent is inadequate for two reasons. One reason is because of the inconsistency between regression analysis and the payment models. The second reason is an arbitrary reduction of the urban adjustment based on the assumption that "differences in capital financing and age attributes (will) even out over time." The AAMC does not agree with the appropriateness of the assumption. Major teaching hospitals have fundamentally different capital structures associated with their acquisition of state-of-the-art equipment and technology.

Tables 1 and 2 at *Federal Register* page 8484 report the results of analyses comparing expected capital payments (assuming several different values for the urban adjustments) and PPS-5 actual costs per case. Using the values obtained in regression analyses (an 8.7 percent adjustment to hospitals in large urban areas and a 6.9 percent adjustment to hospitals in other urban areas) results in payments to hospitals in large urban areas nearly equal to PPS-5 actual costs per case (0.04 percent reduction). Hospitals in other urban areas would be paid less than one percent above their actual capital costs. Therefore, an urban adjustment of at least 6.9 percent is appropriate to recognize differences in capital costs between urban and rural hospitals.

In its payment simulations, the HCFA "standardizes" the costs of capital, assuming that all hospitals should have capital of equivalent age and financing. This standardization is the major rationale for both reducing the large urban area adjustment to 1.6 percent and for eliminating the other urban area adjustment. The Congress should require the HCFA to eliminate this standardization. While the HCFA does "not believe that it is appropriate to recognize the effect of these variables in the payment system for the long run . . . ," the AAMC believes that legitimate differences in the capital structures of hospitals should be recognized. Urban hospitals serve different functions in their communities and are characterized by a very different mix and use of capital.

The AAMC believes that the lack of an IME adjustment and an understated urban adjustment will severely harm teaching hospitals by undercompensating

them for the payment of inpatient capital costs, placing these unique institutions at a disadvantage. The AAMC believes that the Congress will find support for our proposals to include an IME adjustment and increase the urban differential by examining additional regression analyses which use the variables in the proposed capital payment model (i.e. excluding measures of capital age, capital financing, and hospital occupancy) by:

- allowing the coefficients on the urban measures to vary (i.e. not restricting the large urban area variable to its proposed payment level of 1.6 percent); and,
- including more powerful indicators of hospital capital structure such as teaching level or a "high-technology" measure.

In addition, the HCFA should conduct research using all simulations with unstandardized data so that legitimate differences in capital intensity, age and financing are recognized in the capital payment model.

III. EXCEPTIONS PAYMENTS

The AAMC strongly recommends that the capital payment policy be modified with respect to exceptions payments.

The HCFA has proposed the creation of additional payments or "exceptions" for hospitals with very high capital costs, for qualified urban hospitals with more than 100 beds and a disproportionate share percentage of at least 30 percent and for rural sole community hospitals. The exceptions payments are scheduled to be eliminated at the end of the 10-year transition period. The following changes with respect to the exceptions should be made:

A. Exceptions should be based on submitted not final cost reports. The HCFA's proposal requires exceptions payments to be based on data from final cost reports. Because it frequently takes 2–3 years from the time a cost report is submitted until the audit is final, hospitals would be disadvantaged by the delay. In addition, intermediaries are required to verify a hospital's qualification for an exceptions payment and the amount of the payment. Based on those determinations, a hospital may be owed additional funds by Medicare or may owe money to Medicare. This delay may also disadvantage a hospital.

B. The criteria for qualifying as a disproportionate share hospital should be changed so that they are consistent with the criteria for operating costs. A hospital must have a disproportionate share percentage of at least 30 percent to qualify for a disproportionate share exception for capital costs. This is considerably higher than what is needed to qualify as a "high disproportionate share hospital" in terms of operating costs.

Additionally, a number of hospitals have disproportionate share percentages that would not qualify them for exceptions payments for their capital costs, although they receive payments as "high disproportionate share hospitals" for their operating costs.

C. Exceptions should be made for the costs of renovations that are necessary to comply with Federal and State laws and regulations. An example of necessary renovations would be structural building improvements required to comply with the Americans with Disabilities Act. The costs of compliance are often substantial and the timing of the renovations are largely beyond a hospital's control.

D. Exceptions payments should be continued beyond the 10-year transition period by establishing a mechanism for monitoring and evaluating the exceptions criteria and the distribution of exceptions payments. The qualifying criteria should be changed during or following the transition period to help meet the needs of certain hospitals that continue to have high capital costs.

E. The limitation on exceptions payments should be eliminated. The HCFA proposes to limit any exceptions payment to "the difference between the hospital's total Medicare inpatient costs and its total Medicare inpatient payments . . . " The effect of this requirement is that many hospitals that would otherwise qualify for an exceptions payment, will receive none, thus defeating the intent of providing for exceptions payments.

IV. THE DEFINITION OF "OLD CAPITAL"

A. The AAMC strongly recommends that the definition of "old capital" be expanded to include expenses that are currently considered capital-related costs, such as leases, property taxes and the capital costs of related-organizations.

B. The AAMC strongly recommends that a hospital's planned capital assets should be recognized as old capital. The HCFA proposed rule recognizes as old capital only the depreciation and interest for assets reported on the FY 1990 cost report. Hospi-

tals often commit significant resources to projects before they are reported on the Medicare cost report and these resources should be recognized.

V. A PERMANENT PAYMENT FLOOR

The AAMC strongly recommends that the HCFA establish a payment floor for capital of no lower than 80 percent of costs.

A capital payment system based on national average payment rates will cause large amounts of money to be redistributed, with consequences for individual institutions still unknown. A payment floor is the only mechanism that can assure predictability for institutions.

VI. OTHER ISSUES

A. The AAMC recommends with respect to the capital updates:

- the updates be increased;
- the HCFA publish the assumptions used to establish the updates; and,
- there be opportunity to provide for public comment before a methodology for updates for FY 1996 and beyond is established.

B. The AAMC recommends that the HCFA establish separate, less burdensome recordkeeping requirements for hospitals that are paid inpatient capital costs under the Federal rate.

It is also important for the Congress to urge the HCFA to ensure that the audits of capital costs are conducted in a fair and timely manner. Mechanisms should be put into place so that the transition to a fully prospective capital payment system is closely monitored. This will provide opportunities for the HCFA, and the Congress, to make appropriate changes in the payment system for inpatient capital costs.

SUMMARY

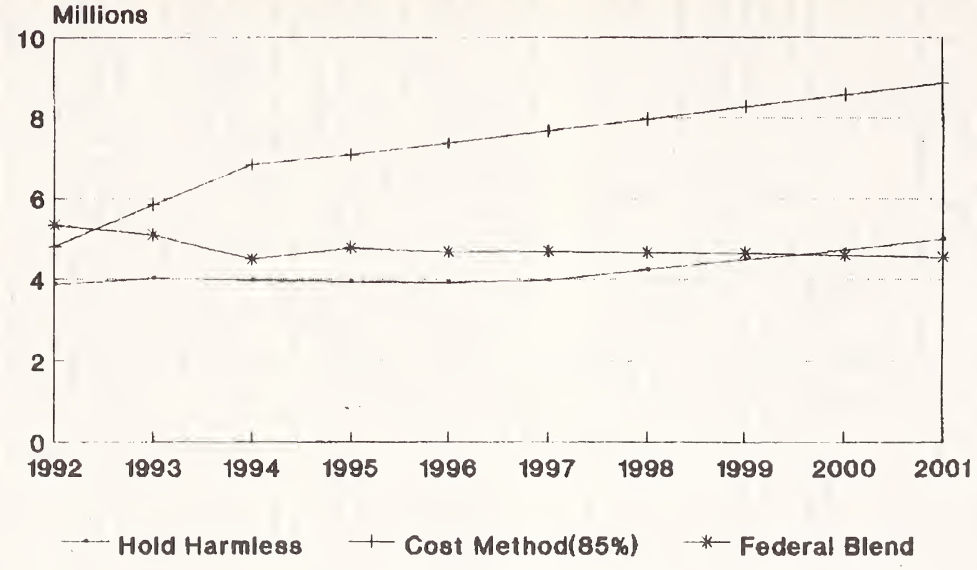
In summary, the AAMC believes that the current hospital-specific-cost-based system of payment for inpatient capital costs is the most equitable system, but realizes that OBRA 1987 requires the HCFA to incorporate Medicare payments for inpatient capital costs into the Medicare prospective payment system. The HCFA has chosen to propose a capital payment system that closely resembles the payment system for operating costs, thereby presaging a day when there will be one prospective system that encompasses both capital and operating costs. Therefore, it is incumbent on the HCFA to treat operating and capital payments consistently.

The AAMC strongly recommends that should the Congress choose to incorporate Medicare capital payments into the Medicare PPS, then the Congress should monitor the implementation of the final rule and evaluate the impact of the new system on the nation's hospitals.

Mr. Chairman, thank you for the opportunity to testify before your Committee on the issue of Medicare capital payment policy. I am pleased to answer any of the Committee's questions.

HERMANN HOSPITAL

Medicare Capital Reimbursement



Without Exception Payments

PREPARED STATEMENT OF THOMAS R. LUGAR

Good morning, Mr. Chairman and Members of the Committee. I am Thomas R. Lugar, Chairman of the Board of Directors of Methodist Hospital of Indiana, Inc. I am accompanied today by John T. Fox, Senior Vice President and Chief Financial Officer of Methodist Hospital of Indiana, Inc. and Bruce B. Melchert, Vice President, Community & Government Affairs of Methodist Hospital, as well as Chairman, Government Relations Committee of the American Protestant Health Association ("APHA"). It is a pleasure to be here on behalf of the American Protestant Health Association to discuss the Proposed Rules issued by the Health Care Financing Administration ("HCFA") relating to a "Prospective Payment System for Inpatient Hospital Capital-Related Costs," published in the Federal Register, 56 Fed. Reg. 8476 (1991) (to be codified at 42 C.F.R. pt. 412) (the "Proposed Rules").

The APHA commends you for the leadership you have shown, Mr. Chairman, in your willingness to confront this issue. In addition, APHA applauds Dr. Wilensky and her staff at HCFA on a very open process in developing these regulations which are markedly better than those published by HCFA in 1987. Although we steadfastly continue to believe that no change from the current system is necessary, we believe these Proposed Rules, together with the changes which I will propose today, will be workable, but probably only in the short run. We anticipate that changes to this new capital payment policy will inevitably follow, as did certain changes to the basic PPS law adopted in 1983. We appreciate the opportunity to discuss these proposed changes with all of you.

AMERICAN PROTESTANT HEALTH ASSOCIATION AND METHODIST HOSPITAL

The American Protestant Health Association ("APHA") is a national association of church-related, not-for-profit hospitals, health systems and homes for the elderly, comprising nearly 500 institutions. APHA hospitals include a significant number of major teaching hospitals and disproportionate-share hospitals. At the same time, there is a very substantial number of small urban or suburban facilities, as well as some rural hospitals. Because our average capital cost per case is over $900, the proposed changes in the Medicare capital payment policy will have a large negative effect on a substantial number of hospitals and will benefit favorably only a few.

A member of the APHA, Methodist Hospital of Indiana, Inc. ("MHI") is a not-for-profit, general acute care teaching hospital located in Indianapolis, Indiana. MHI has a licensed bed capacity of 1,175, with 43,056 inpatient discharges and 884,793 outpatient occasions of service for Fiscal Year 1991, which makes the hospital the largest provider of health care services in Indiana. MHI provides comprehensive health care services to its patient population involving primary, secondary and tertiary care services on an inpatient, referred, clinic and emergency outpatient basis. The hospital provides organ and bone marrow transplant services and operates a hospital-based emergency medical helicopter service.

MHI has made a commitment to provide a quality health care delivery system to the growing needs of Indianapolis and Central Indiana. In analyzing the market, MHI anticipates that within five years, inpatient discharges will increase to 47,460, over a 10% growth, and outpatient occasions of service will be 950,000, over a 7% increase. During the past fiscal year, the hospital provided over 27 million of uncompensated services to the indigent. Medicare comprises approximately 40% of the inpatient service with an average capital cost per discharge of over $1,200.

The proposed change in the Medicare capital payment policy will have a substantial negative impact on MHI, and hospitals like it, and will limit the ability to provide quality health care to the communities which we serve.

As more fully discussed below, while we do not believe that any change from the current system is either necessary or reasonable, the APHA believes that the Proposed Rules should be revised to provide protections regarding a number of issues.

BACKGROUND

The Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-208, Section 4006(b)) mandated that capital payments be incorporated into Medicare's prospective payment system ("PPS") by October 1, 1991. This system would replace the current reasonable cost-based payment methodology for capital-related costs. That legislation was based on capital data from FY 1985, the first year in which most hospitals were fully in PPS. At that time, under PPS, there were substantially higher margins than there are today and all PPS hospitals were still under 100% capital cost reimbursement.

PROPOSED RULES

The Proposed Rules would establish a standard Federal rate for all capital-related inpatient hospital costs based on the estimated FY 1992 national average Medicare capital costs per discharge for hospitals paid under PPS. Certain adjustments would be made. Based on the FY 1990 cost report, hospital-specific payment rates would also be determined for all hospitals. The Proposed Rules provide a ten-year transition period for a blend of Federal payments and hospital-specific payments to a fully Federal payment rate. During the transition period, hospitals that have an FY 1990 hospital-specific rate for capital above the Federal rate will receive payment under a "hold-harmless" methodology, which is the higher of either: 90 percent of the "old" capital costs, adjusted for budget neutrality, plus a payment for new capital costs based on a proportion of the newly created Federal rate; or 100 percent of the Federal rate (or the applicable blend of hospital and federal, whichever is lower).

For example, in the first year of the proposed transition, payment rates would be 90 percent hospital-specific and 10 percent Federal. Thereafter, the hospital-specific portion would drop by 10 percent a year and the Federal rate would be increased by the same percentage. Eventually, hospitals would be paid a 100 percent Federal rate. Hospitals with a hospital-specific rate below the Federal rate are to be paid a blend of the Federal rate and their estimated hospital-specific rate trended forward each year. Under either method, there are exceptions for certain hospitals: GT3i.e., rural sole community hospitals and large urban hospitals with low-income patient percentages of over 30 percent.

For FYs 1993 through 1995, the Federal and the hospital-specific rates will be updated based on actual increases in the capital-related costs per case per discharge that occur two years previous to the current Federal fiscal year. Thereafter, the update will be determined through a capital "market basket," an index that takes into account new technology and changes in capital requirements. In addition, aggregate capital payments in FYs 1992 through 1995 must be budget neutral.

Under the Proposed Rules, "old" capital is defined as allowable Medicare inpatient depreciation and interest expenses for capital assets maintained on the hospital's premises and reported as being used for patient care on the hospital's FY 1990 Medicare cost report. Not included in "old capital" are leases, rentals, licenses, royalty fees, insurance, taxes, and related organization capital costs for assets not maintained on the hospital's premises.

APHA PROPOSED CHANGES

First, hospital *leasing* costs for equipment and buildings are specifically excluded in the definition of "old" capital (but *included* in the "new" capital definition). This must be changed since today most responsible hospital administrators lease high technology equipment with a payout period of two to five years. As technology is continually evolving, hospital administrators do not want to be left owning an obsolete piece of equipment. A one-time audit by the fiscal intermediary could be done to identify such qualifying leases. We also believe that insurance, licenses, taxes and related organizational expenses should be included in the definition of old capital. Indeed, it is estimated that only about 60 percent of a hospital's "old" capital will be reimbursed under the hold-harmless provision. Hospital leasing costs should be included in the hold-harmless scheme.

Second, the Proposed Rules require that *old capital* projects, to qualify for the transitional 10-year hold-harmless payment, must be identified in the FY 1990 cost report. We believe that this provision is needlessly restrictive, and that a fairer definition is found in the old Section 1122 cost containment and quality control rules published by HCFA in response to the 1972 Medicare amendments, but which were repealed in 1987 with the demise of health planning. In those Section 1122 regulations, the capital expenditures include a "force account expenditure," approved by the facility board which exceeds $100,000; $100,000 in 1972 dollars relates to approximately $300,000-$400,000 today. We believe that represents a fairer application of the definition of old capital and one with which most hospital administrators are familiar. In addition, we believe that the definition of old capital should include capital assets, the costs of which exceed the threshold limit, for which the hospital has made a commitment. Accordingly, while we support the alternative approach in the Proposed Rules that defines *obligated* capital where a hospital has demonstrated financial *commitment* by incurring substantial expense, we believe the $750,000 level is inconsistent with today's capital spending decisions and urge a more realistic number in the area of $300,000-$400,000.

In addition, we believe the legal commitment date and completion date should be flexible based upon the types of facilities. Major regional treatment centers and

teaching institutions must be protected from the uncertainties of the proposed rules and the vagaries of the construction industry. A more realistic commitment date would be September 30, 1991 with a completion date of December 31, 1994.

Third, there should be a real hold-harmless provision either mandated by the. Congress or adopted in the Final Rule. We suggest two changes to the current formula. We strongly believe that a *permanent payment floor* should be imposed so that no hospital would receive less than 80 percent of its capital costs (capital costs less 20 percent). In addition, there should be a special payment floor established for sole community hospitals and rural primary care hospitals somewhere between the permanent payment floor for all hospitals and 100 percent of costs. The inherent problem of imposing an average capital payment policy on all hospitals is that all hospitals are not the same, especially with regard to capital. *Capital is cyclical in nature and affects each hospital differently.* Accordingly, there needs to be an equitable mechanism built in that will level the peaks and valleys of an averaging system. Implementation of a permanent payment floor below which inpatient capital payments could never fall would help to significantly reduce risk by limiting the shortfalls that any individual hospital could experience under the proposed payment system.

In addition, the current formula under the hold-harmless provision should be changed to enable the hospital to receive the higher of the applicable blend or 100% of the Federal rate, rather than the lower. This would allow institutions, during the years of capital transition, to blend Hospital Specific Rates and Federal Rates rather than expedite the 100% fully Federal methodology prior to the end of the blend period. This will provide protection to the institutions on a more realistic basis.

Fourth, we strongly suggest that hospitals be allowed to elect *not* to go under the hold-harmless provision and be paid under the Fully Prospective Payment Methodology Blend. Depending upon a hospital's capital cycle and patient acuity, a one-time election to go directly to the prospective system could accomplish the goal without disturbing budget neutrality or creating uncertainty in the system. In addition, the cost reporting requirements under the hold-harmless provision are very extensive and cumbersome for both the hospital to maintain and the fiscal intermediary to audit for each year during the transition period. Such time-consuming record-keeping and auditing could be eliminated if hospitals were given the option to opt out of hold-harmless.

Fifth, the Secretary's discretion to unilaterally determine and implement the capital *update* must be circumscribed. Under the Proposed Rules, taking into account budget neutrality and the capital market basket, the Secretary, after FY 1995, could impose a zero capital update or a lower capital update number in FY 1996 than a hospital had in FY 1993. The methodology for updating the payment rates after FY 1995 must be clearly articulated in the proposed payment system so that hospitals can reasonably project the long-term impact of the Proposed Rules. Specifically, the methodology should provide for updates that ensure that Medicare capital outlays after FY 1995 are equal to 100 percent of capital costs in those years, after budget neutrality at 90 percent of costs has expired.

Sixth, the Proposed Rules provide for all transfers to be counted as discharges for the base period, which suggests that all future transfers will also be counted as discharges for consistency purposes. This also seems to suggest that the proposed Federal rate is adjusted for the inclusion of transfer patients, which would substantially dilute the Standard Federal Payment Rate to large non-transferring institutions. Under this rule, a conflict may exist for some hospitals—whether to keep the patient and treat him or her or to transfer the patient and perhaps put the patient at risk. This could result in an added expense to the Federal government and the larger institutions which receive transfer patients. We suggest that transferring hospitals receive a payment which is representative of the services consumed at the facility, this payment system can be structured similar to DRG transfer payments made under the PPS system, and that hospitals which receive transfer patients be reimbursed the full capital payment.

Seventh, HCFA has developed one National Standard Federal Payment Rate. We believe that a system of having only one rate significantly distorts the payments made to large urban health care providers and to small and rural providers. We recognize HCFA's intention to protect the special needs of the rural and sole community providers, but we believe that protective measures have already been installed in the Proposed Rules and do not need to be coupled with the Federal payment Rate at the expense of the large urban hospitals.

We believe that, for large tertiary providers, the average reimbursement under the proposed policy will be so significantly below the capital cost of providing serv-

ices that the ability to provide adequate and quality services in the future will become questionable; small rural areas, however, will be provided with payments in excess of their costs and, therefore, their needs.

We recommend that the Standard Federal Payment be divided into three separate rates for large urban, other urban and rural hospitals and that such amounts would be specific to each of the nine geographic regions established by HCFA. Upon establishing the various Regional Standard Payment Rates, the case mix index could be applied to adjust the payment to reflect services that the institution provides. With only one Standard Federal Payment Rate, the case mix index alone is not sufficient to reflect the cost per discharge between major acute care providers and rural general providers. The variance in the weights, without a variance in the Federal Payment Rate, will not adequately reflect the capital needs or necessary capital spending of those institutions with longer lengths of stay and greater intensity of services. If the standard Federal amount is not adjusted by region and type of provider, there must be another mechanism added to the current formula to adjust the base or undue substantial gains will be made by the low discharge service providers.

Finally, such Federal payment should not be adjusted by the wage index, as capital costs are largely non-labor equipment expenditures. We believe that a system based upon standard federal payments by geographic region, as noted above, is a better geographic payment adjustment than the wage index.

DISCUSSION

The PPS with incorporated capital will not be directly responsive to hospital and community characteristics that affect a hospital's need for capital. New substantial capital expenditures, *i. e.,* renovations and expansions, are not anticipated under the Proposed Rules. In addition, some anticipated expenses must be included in the methodology for the capital update. For example, the American Hospital Association estimates that over the next eight years the financial impact of the Americans with Disabilities Act on the hospital industry will be approximately $81.75 billion in capital expenditures. These appropriate and valid adjustments for capital spending must be considered and accommodated for in the Final Rule.

It is important for the policy-makers to consider the classes of hospitals that could be adversely affected by the Proposed Rules. Some of these hospitals, in fact, are hospitals that were created under the Hill-Burton Act, 42 U.S.C. § 291-291o-1 (1944). In an effort to assist States in carrying out their programs for the construction and modernization of public and other non-profit community hospitals and to furnish adequate hospital, clinic, or similar services to the people, the stated intention of the Hill-Burton Act is that Federal monies be appropriated for the construction of such projects, as well as for the development of new or improved types of physical facilities for medical, diagnostic, preventive, treatment or rehabilitative services. A prospective payment system for capital such as the one proposed effectively will undermine the stated Congressional declaration of purpose of that Act. Many community-based Hill-Burton hospitals will be very adversely affected by these Proposed Rules. Hopefully, in the Final Rule, HCFA will reconcile these two conflicting policies.

The changes being brought about by the Proposed Rules will have a disparate impact on a wide range of hospitals. As indicated, some of these effects are anticipated, while others are not. This inevitably will cause uncertainty among hospital administrators, particularly at a time when they are struggling with the issues of health care reform. For example, at Methodist Hospital, we have estimated that under the Proposed Rules we will lose $20 million over an eleven year period. This illustrates vividly the necessity for a permanent payment floor. We at Methodist Hospital are particularly concerned that the Proposed Rules do not address teaching hospitals and the additional costs related thereto. We believe that either the indirect medical education formula needs to be adjusted to include the additional capital expenses, or that an adjustment factor be established and applied to the Federal Payment Rate for teaching institutions. In addition, we anticipate the need to expand some of the existing facilities so that the hospital can remain committed to providing quality health care.

On the other hand, another member of APHA, Christian Health Services of St. Louis, Missouri, which includes four rural and four urban institutions, anticipates that its facilities will all gain under the Proposed Rules. For example, the estimated total amount of gain for these institutions is $8.6 million. For each of the hospitals, the Federal rate is in excess of the hospital specific rate. Based on these estimates, all of these hospitals will be paid under the fully prospective payment methodology at a rate higher than under the reasonable cost methodology. The disparities be-

tween these two systems—Methodist and Christian—should be addressed and alleviated.

Yet, despite the fact that the financial state of the institutions of Christian Health Services will improve, Christian Health Services does not fully support the Proposed Rules. A major concern of Christian Health Services relates to the uncertainty of estimating future payments because the Proposed Rules are vague and underinclusive, *i.e.,* the manner in which updates are to be calculated beyond FY 1995 is uncertain and the definition of old capital is inadequate. The ability of these institutions to do long-term planning for expansion and rehabilitation is clearly undermined by the Proposed Rules, and also demonstrates the need of the permanent payment floor.

In addition to the changes we propose today, we specifically endorse the recommended changes of the Prospective Payment Assessment Commission ("ProPAC"), the American Hospital Association and the Catholic Health Association. Under the Freedom of Information Act, by letter dated May 17, 1991, we have requested copies of and access to any and all records, documents or other information HCFA has in its possession that pertain in any way to the Proposed Rules.

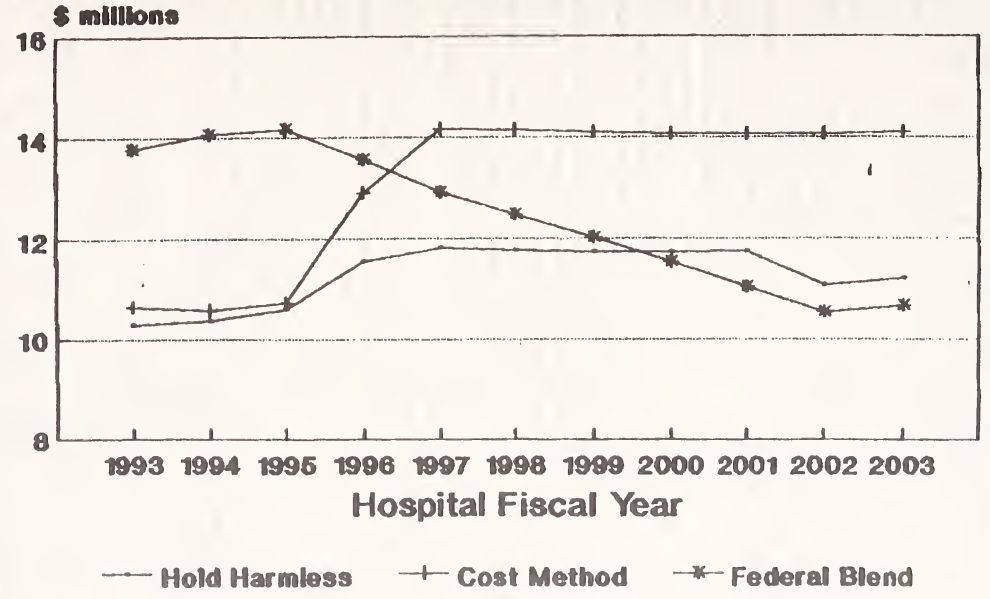
CONCLUSION

For all the reasons we have stated today and expressed to HCFA in our formal comment letter, we urge you, Mr. Chairman, and all of the members of this Committee, to reconsider the necessity of implementing a prospective payment system for capital costs; however, if Congress determines that capital is to be reimbursed on a prospective basis, APHA supports the adoption of modifications to the proposal in order to reduce the adverse impacts on the health care system.

Thank you for the opportunity to appear today and I will be pleased to respond to any questions you and your colleagues might have.

METHODIST HOSPITAL OF INDIANA

Medicare Capital Reimbursement



Prepared Statement of Jack W. Owen

Mr. Chairman, my name is Jack W. Owen, interim president of American Hospital Association. On behalf of AHA's nearly 5,400 member hospitals, I am pleased to testify on the proposed prospective payment system for Medicare inpatient capital-related costs.

GENERAL CONCERNS

We have grappled with the issue of how to design a fair payment system for hospital investment in the plant and equipment for Medicare inpatient care since the implementation of the Prospective Payment System (PPS). While this capital proposal is a significant improvement over its predecessors, it is nevertheless fraught with many of the same problems of previous capital payment proposals. The potential benefits of a prospective payment system for capital, in terms of organization, delivery, and cost of health care, should outweigh the disruption brought about by its adoption. AHA does not believe that this proposal, as it is currently structured, meets that test, and we strongly oppose the implementation of this proposed rule.

Before discussing our specific concerns about and recommendations for improving the proposal, let me tell you why we question the need for a prospective payment system for Medicare inpatient capital costs. Hospitals already have significant incentives to closely evaluate capital expenditures. Operating expenses constitute about 90 percent of hospitals' costs for the care of Medicare beneficiaries, and these costs are already paid on a prospective basis. capital expenses make up the remaining 10 percent of costs and are currently paid on a discounted cost pass-through basis, such that hospitals receive only a portion of these expenses. Hospitals have already experienced shortfalls of several billion dollars under Medicare's discounted pass-through system and will continue to do so under current law.

Capital spending decisions are not made in a vacuum nor are they based on how a single payer, such as Medicare, reimburses capital costs. They are based on a variety of considerations including community need and the overall financial condition of the institution. The low margins hospitals are currently experiencing under PPS are forcing hospitals to choose those investments in patient care that make the most sense over the long term. As a rule, hospital managers and trustees go through an extensive review process to see whether the necessary demand for the service is there to support the investment.

National data reflect this conservative attitude toward capital spending. Since 1984, capital costs have averaged about 9 percent of operating costs. Further, year-to-year increases in capital costs per adjusted admission have declined from over 11 percent during the mid-1980s to slightly more than 8 percent last year.

One argument cited for changing capital payment policy is that the payment system should provide incentives for sharing capital resources, thereby curtailing unnecessary duplication of equipment. In many hospitals this is already occurring. More and more, hospitals are teaming up to provide services to their communities. In some situations, however, it just isn't practical to share capital resources. Transferring an inpatient to another facility or central community location for diagnostic tests presents logistical problems, not to mention the disruption to the patient and the potential threat to a patient's condition.

Another argument for changing capital payment policy is that the new policy would encourage hospital consolidation and result in more efficient delivery of care. Again, this is already occurring in many areas. More than 82,000 hospital beds have been removed from service since 1983. In addition, there were over 300 hospitals involved in mergers, consolidations, acquisitions, or other similar transactions between 1980 and 1990. In other areas such consolidation may not be feasible. There are many communities where there is only one hospital. In areas with more than one hospital, some consolidation has already occurred, but a more significant barrier to consolidation than the payment system has been Federal anti-trust laws. There is anecdotal evidence that beneficial sharing or consolidation arrangements have been curtailed or simply not considered because of Federal barriers.

In short, prospective payment for Medicare inpatient capital costs does not offer communities, patients, or providers any benefit over the current payment system. Incentives are now in place to ensure that hospitals make wise investments in future patient care. In our view, the proposal will merely add to the disruption and disarray of our nation's health care system. Many hospitals will be hurt under this rule not because of their relative efficiency, but because the payment system is based on averages. Yet, there are no "average" hospitals. capital dollars will be shifted without policy justification and will only exacerbate the problems of PPS at a time when hospital resources are already stretched to the limits.

KEY PROBLEMS

There are three major problems with the proposed rule as it is currently structured that we believe will undermine both the system itself and hospital financial conditions.

Predictability of Payment

Predictable payment is critical for capital decision-making, because capital requires large, up-front financial commitments. In modeling the proposed rule using projection factors provided by HCFA, AHA and other hospital associations project different impact from the proposed rule than does HCFA. In particular, there are major differences in projections of aggregate payments to hospitals, even in the first year of the payment system. consequently, we are concerned that many of the factors and assumptions used to design the payment system may be inaccurate. We are particularly concerned about how the payment system in the future might be modified by HCFA should the assumptions upon which the regulation is based turn out to bear little relationship to reality. Hospitals that appear to benefit from the new policy may benefit only "on paper" and may in the future face severe payment shortfalls. These major conflicts in estimating the impact raise real questions about what payments to hospitals actually will be in the future. Hospital managers and lenders will face considerable doubt in trying to predict a revenue stream under this rule.

Adequacy of Payment

The proposed payment system may not provide adequate payments to hospitals for several reasons. First, according to projections by CBO, national trend factors by AHA, and analyses by the prospective payment Assessment commission (ProPAC), the proposed rule appears to have underestimated capital growth between FY 1988 and FY 1992, making the per case base rate in FY 1992 lower than it should be. Second, the rule does not make explicit the method for updating payment rates after FY 1995 and only adds to the uncertainty of this rule for hospital decision-making. Third, in FY 1996, it is projected that aggregate capital payments will equal only 93 percent of costs. Unless payments after FY 1995 are made budget neutral to 100 percent of costs, payments may not be adequate, and spending potentially could be set at artificial levels due to congressional scoring of Medicare capital spending after that year. Fourth, unless their hospital-specific payment rates are adequately updated, hospitals paid under the fully prospective blend during the transition would be vulnerable if they undertake any major necessary capital acquisition. Finally, the definition of "old" capital costs is inconsistent with the current, accepted definition of capital costs. As a result, certain hospitals would be treated unfairly merely because they chose, for example, to lease their capital assets instead of purchase them.

EQUITY OF PAYMENTS

One of the proposed rule's major weaknesses is the manner in which the available pool of capital dollars for inpatient services would be redistributed across hospitals. There are a number of adjustment factors included in the proposed rule to account for variations in capital costs across hospitals, due to, for example, the types of patients a hospital treats (i.e., case mix). unfortunately, the adjustment factors included in the proposed rule are not structured appropriately, and others that are relevant are not included. Although imperfect, the current adjustments to operating payments under PPS explain a majority of the variation in operating costs across hospitals and, thus, provide some equity. These same variables explain only about one-third of capital cost variation across hospitals. Moreover, the set of variables chosen to adjust capital payments under this proposal explain even less than one-third. What this means is that this proposed capital payment system would, in effect, randomly redistribute nearly 58 billion in capital payments across hospitals in FY 1992.

IMPACT

The unpredictability, inadequacy, and inequity of payments adds up to a payment policy that is seriously flawed and would lead to unnecessary disruptions: some hospitals will "win" big and others will "lose" big, with undesirable effects on access and quality. This is not surprising given that the proposed payment system is in essence predicated on averages whereas capital costs range widely across hospitals. AHA analyses show that all categories of hospitals could be hurt by this proposed rule, but certain "types" of hospitals are likely to be hurt disproportionately. These

include: hospitals that recently undertook major capital investments or will do so in the near future; hospitals that treat more severely ill patients (i.e., high case mix); urban hospitals; mid-sized hospitals; hospitals located in the southern regions of the country; investor-owned hospitals; and hospitals with relatively greater reliance on debt. All hospitals will face additional administrative burdens from the rule.

At issue here is whether this policy will achieve its stated objectives. AHA believes that certain changes must be made in the proposed payment system if it is even to begin meeting hospitals' capital payment needs. The payment system must accommodate the way capital decisions and financing work in practice.

SPECIFIC RECOMMENDATIONS

I would like to turn to some specific recommendations for improving the rule. Our overriding goal is to mitigate the severe impact and swings in payment that we foresee for hospitals so that hospitals can both meet current obligations and respond to future patient care needs.

Expansion of Exceptions Process to Provide a Permanent Payment Floor

Through exceptions payments, the proposed rule provides temporary protection for hospitals that would experience major capital payment shortfalls during the transition period. In effect, these exception payment provisions establish de facto payment floors of 67 percent of actual costs for all hospitals and about 80 percent of actual costs for rural sole community providers and urban, high disproportionate-share hospitals. Given that there is no agreement among experts on what the impact of the proposed rule would be and given known problems in accounting for variations in capital costs, AHA recommends that the exceptions provisions be expanded.

The temporary exceptions processes should be expanded to provide a permanent payment floor for all hospitals that is higher than the payment floor provided for in the proposed exceptions process. In addition, a special exceptions payment floor for sole community hospitals and rural primary care hospitals should be established at a higher level than the payment floor established for all hospitals in order to provide these essential institutions with additional protection. These hospitals have in the past been exempt from all payment reductions under the discounted cost pass-through system for capital.

Expanding the exceptions processes in this way would minimize the cloud of uncertainty surrounding this proposal. It would offer hospitals protection from major hardship due to the flaws in the proposed payment system. At the same time, it would force hospitals to share a major portion of the risk of any necessary investment in patient care.

Changes to Improve Adequacy of Payments

The issue concerning adequacy of payments is rather simple, but it is essential to hospitals. Medicare must pay its fair share, and that means aggregate payments must equal the financial requirements for providing services to Medicare beneficiaries. We recommend the following to accomplish this. First, in establishing the FY 1992 base rate under the payment system, HCFA should use AHA capital cost trend data and CBO projections of these trends. Second, for payment rates beyond FY 1995, the final rule should clearly state that updates for this period will be based on actual increases in capital-related costs. Third, after budget neutrality at 90 percent of costs expires in FY 1995, the proposed payment system should provide for updates that ensure that Medicare capital outlays are equal to 100 percent of capital costs in subsequent years. Finally, to minimize the need for exceptions for hospitals paid under the fully prospective blend during the transition, the hospital-specific portion of the blend should be based on actual hospital-specific costs for each year of the transition rather than on an updated base year rate.

True Hold-Harmless for Existing Capital Obligations

The hold-harmless payment provision included in the proposed rule falls short of offering full protection for existing obligations. The proposed rule would penalize certain hospitals with prior commitments because of the manner in which existing obligations—that is, "old" capital—would be considered eligible for payment. We recognize that it is difficult to design a prospective payment system for capital that balances the needs of those hospitals with existing commitments against those that need to undertake future commitments, especially when there are mandated budget constraints. Nevertheless, to provide a true hold-harmless provision and to facilitate more equitable payments across providers, we recommend that definition of "old" capital be consistent with the current Medicare definition of capital-related costs.

Thus, the definition should include leases, taxes, insurance, home-office capital costs, and other capital-related costs that are now recognized. In addition, the treatment of refinanced debt needs further clarification. Interest expense on debt that is used to refinance that portion of "old" capital assets should be treated as "old" capital costs.

The effective date of the final rule should be established as the cut-off date for determining when capital costs are eligible for payment under the rule's hold harmless provisions. Setting a cut-off date on a specific day, rather than linking the cut-off date to individual hospital cost-reporting periods would minimize confusion and provide more equitable treatment of providers. Further, there are many situations where capital has been obligated, be it through a bond agreement, a merger, a State's regulatory process, or other circumstances where there is an enforceable contract or where a hospital has already expended substantial funds. AHA recommends that such obligations made by the cut-off date be defined as "old" capital.

Changes to Improve Equity of Payments

Capital costs vary across hospitals and from year to year even among hospitals with similar characteristics. This variation is largely unaccounted for by the payment adjustments in the proposal. The adjustments were developed based on one year's data from less than 40 percent of PPS hospitals. Also, in identifying and evaluating these proposed adjustments, no effort was made to look at their combined effects. For these reasons, among others, the proposed adjustment factors are inadequate and cause vast differences in the estimated payments between "winners" and "losers" under the rule. AHA strongly recommends that the proposed payment adjustments be reevaluated using a larger data set and several years' worth of data. In addition, other critical adjustments found to be significant in helping to account for variations in capital costs should be included in the payment system. These modifications will not require additional funding, but they will help better match payments to individual hospital experience.

Case mix: Hospitals that, on average, treat more severely ill patients will be disadvantaged relative to other hospitals under this payment system. This is because the current DRG weighting system for operating costs may not accurately reflect the use of capital resources by hospitals. For example, a hospital that treats a patient for kidney stones with lithotripsy would be underpaid relative to its capital costs. While this procedure is very capital intensive, the relative DRG weight on which PPS operating payments are based is relatively low.

It may be necessary to develop a separate weighting system for capital payments, at least where there are justifiable and significant differences from DRG weights for operating payments. As an interim step, the adjustment to capital payments for case mix must be revised to more accurately reflect the underlying relationship of capital costs to case mix.

Geographic Variation in Costs: Hospitals incur different costs for capital, in part due to local variations. For example hospital construction costs vary from one region of the country to another. The proposed rule includes an adjustment to payments for local capital cost variation based on a hospital's area wage index. Unfortunately, this index is not necessarily related to capital costs. AHA recommends that a more appropriate adjustment be developed and tested as soon as possible. In the meantime, the use of this adjustment should be monitored closely, and problems due to its limitations should be considered grounds for appeal.

Disproportionate Share: Disproportionate-share hospitals deserve special treatment under payment policies given the role these hospitals play in meeting community health care needs. The proposed rule singles out urban high-disproportionate share hospitals only for additional capital payments when in fact all disproportionate share hospitals should receive an adjustment.

Teaching Status: Under the proposed rule, teaching hospitals would not receive an adjustment to their capital payments. Our analyses suggest that the relationship between capital costs and teaching status is complex and that teaching hospitals with high case-mix indices could be particularly disadvantaged under the proposed rule. Thus, AHA recommends that an adjustment should be made to hospital capital payments for teaching status.

Capital Cycle: According to both AHA and HCFA analyses, next to case mix, the timing of capital acquisitions is the most significant factor in explaining why capital costs vary so widely across hospitals. Yet an adjustment for this factor is not included in the proposed payment system. AHA recommends that such a adjustment be developed and applied permanently under a prospective payment system for capital. This adjustment would help distribute dollars to hospitals when these monies are most needed to undertake investments or service debt. Such an adjustment would

not cost Medicare any additional money and would help minimize the need for exceptions.

Reliance on Debt: Again, according to both AHA and HCFA analyses, reliance on debt accounts for significant differences in capital costs across hospitals. Again, however, the proposed rule would not include an adjustment to payments for this critical factor. Hospitals have unique characteristics and financial conditions that require them to borrow at different levels, at different interest rates, and for different lengths of time. AHA recommends that an ongoing adjustment for reliance on debt also be developed. Without such an adjustment, we believe that the ability of many individual hospitals to meet cash-flow requirements for current and future debt service would be jeopardized.

Property Tax: The cost of property taxes should be an explicit adjustment to capital payment rates for hospitals that pay those taxes and should not be included in the Federal base rate paid to all hospitals, as is currently the case under the proposal.

Special Appeals Process

We can foresee a number of circumstances in which individual hospitals may have to incur capital costs beyond their control, for example, to comply with state life/safety codes or other government-mandated changes. It would not be fair to constrain capital payments to such hospitals. Further, a payment system based on averages and one that is as problematic as this one must provide an avenue within which to address inequities. For these reasons, we believe a special appeals process should be established for hospitals incurring major unexpected capital costs beyond their control and for hospitals that are concerned that their ability to provide needed services to their communities would be jeopardized by capital payment shortfalls.

Necessary Safeguards

Hospitals have shared with congress the struggle to ensure that the aggregate level and distribution of payments under Medicare and other public insurance programs are sufficient to allow hospitals to meet beneficiaries' needs. Unfortunately, the gap between costs and payments grows wider every year. We are particularly dismayed about arbitrary changes made in payment policy by HCFA and the difficulties these changes cause. It is difficult for hospitals to cope with all these changes and still maintain access to quality services.

We have two other recommendations to help assure adequate payment levels under a prospective capital payment system. First, congress should prohibit HCFA from imposing regulatory changes that would result in major reduction or redistribution of capital payments unless those proposed changes are reviewed by ProPAC and formally approved by Congress.

Second, to further ensure spending accountability, HCFA should be required to obligate annually the total amount of capital dollars within the bounds of budget neutrality. Unused funds set aside to make additional payments for exceptions or outliers should be returned to the pool of capital dollars and used to increase payments to all hospitals, not realized as "savings" to the Medicare program.

CONCLUSION

AHA strongly opposes the proposed rule as it is currently structured, and questions the need for and wisdom of its implementation. The capital incorporation proposal was first developed in response to rising capital spending of a decade ago and in response to perceived excess capacity and unnecessary duplication of equipment. Over the past several years, however, spending has slowed. The vast majority of capital expenditures undertaken by hospitals today are prudent and oriented toward meeting future health care needs of Medicare beneficiaries.

Whether and how hospitals would be able to adapt to this proposed payment system is an open question, but judging from analyses of the proposed rule and its projected impact, it is clear that there will be considerable redistribution of capital dollars among hospitals without any underlying rationale. Hospitals will be paid essentially the same amounts regardless of their relative efficiency, and the timing and level of the payments will not match the needs of individual institutions and the communities they serve.

Uncertainty about future capital payments means that planning for capital acquisitions will be more difficult and risky and that the costs of financing investment for future patient services will be more costly.

In sum, the potential disruption to the hospital field at a time when hospitals are already in a vulnerable financial position far outweighs any perceived benefit asso-

ciated with adopting this payment system. The detailed set of recommendations outlined here are intended to help resolve some of the more egregious limitations of the proposed rule. We believe that these recommendations will provide more predictable, adequate, and equitable Medicare capital payments and better allow hospitals to make needed investments in patient care. AHA will continue to work through the regulatory process, your committee, and others in Congress to fashion a payment system that is fair and achieves our mutual objectives for needed, quality services for Medicare patients.

PREPARED STATEMENT OF JUDITH P. SMITH

The Catholic Health Association of the United States is pleased to present testimony before the Senate Finance Subcommittee on Medicare and Long Term Care regarding the Health Care Financing Administration's (HCFA) February 28, 1991 Notice of Proposed Rule Making on Medicare payment for inpatient related capital costs. The Catholic Health Association (CHA) is the national organization of Catholic hospitals and long-term care facilities, sponsoring organizations and systems, and other health and related agencies and services operated as Catholic. Our members include 597 hospitals, and 58 health systems. Nearly 34 percent of these hospitals (184) are Medicare Disproportionate share providers while 13 percent (113 hospitals) are designated trauma care centers for their respective communities. CHA member hospitals have served Medicare and Medicaid beneficiaries since the inception of the programs, and in 1989 provided nearly 18 million days of care to the Medicare population.

CHA realizes that HCFA is required by law to implement a prospective payment methodology for Medicare inpatient capital costs after October 1, 1991. We appreciate the consultative process that HCFA followed in developing this proposal, and commend HCFA for its efforts in attempting to address the complexities of hospital financing in crafting this regulation. That effort, the resulting NPRM and the substantial additional changes required, however, highlight the underlying problems: the nature of capital financing is so substantially different from operating costs that any regulation will have to be so complex as to be virtually incomprehensible, and will still arbitrarily redistribute funds with little analytic justification. The capital payment changes will exacerbate the financial distress caused by prior year budget cuts in both capital and operating payments, and the unfortunate fact that many State Medicaid programs fall far short of reasonable payment levels.

CHA believes it vitally important to recognize the fact that there is no urgency for change at the present time. The constraints of private payors, the Medicare hospital inpatient Prospective Payment System (PPS), and Medicaid, have already constrained capital spending. *Current payment policies are doing an effective and fair job of restraining the rate of growth in Medicare capital expenditures. There is, therefore, no need for a new and untested policy that would be expensive to implement and operate, and be unpredictable in its result.*

These financial problems, coupled with the enormous uncertainties in the regulation—ranging from definitional questions to thresholds for exceptions and the value of the update in future years—yield a situation in which the proposal is, in its current form, unnecessary, inappropriate and unacceptable.

CAPITAL REGULATIONS ARE NOT NEEDED

The statutory directive and the proposed regulation are based on the assumption that Medicare's current treatment of inpatient capital makes capital essentially free to health care facilities. Under this assumption, the facilities can be economically undisciplined, leading to excessively large Medicare capital expenditures.

This assumption, however, ignores the facts. Medicare's existing policy of annual budgetary constraint on operating payments, and Medicare's 10-15 percent discount on payment for capital costs exert a strong Medicare brake on spending. These Medicare policies, coupled with comparable payment constraints in the private sector, and notoriously low Medicaid payment rates, send a strong set of signals to hospitals to control their inpatient capital spending.

Hospitals are already at substantial risk for their capital expenditures, because those expenditures have operating cost implications. The data indicate this reality: *capital costs have already been constrained in a manner parallel to operating costs; and the rate of growth in Medicare capital costs per discharge has declined substantially.* This is because under Medicare about nine out of every ten dollars comes through the already constrained PPS system. Hospitals cannot spend the 10th

dollar—the capital dollar—and the other nine dollars are severely constrained. Thus, the hospital has to control both capital and operating spending.

PAYMENT PREDICTABILITY IS LACKING

A fundamental goal of any capital payment policy should be to enable predictable forecasting of Medicare hospital revenue streams. This is important because capital obligations represent fixed, long term commitments.

As noted earlier, the current environment is increasingly placing hospitals at risk for costs, requiring them to accurately forecast revenue streams. Beyond hospital management, predictability is important to those who hold hospital debt or equity shares. The certainty of a capital revenue stream is a key barometer of lender confidence in an institution, and this will determine its ability to access funds in the future.

Our specific comments, which follow, identify many serious problems with each of the proposed rule's principal elements. Together, these problems create a situation in which it is nearly impossible to predict with a sufficient degrees of accuracy either the amount or distribution of capital payments over time. Thus, the proposed rule would, in its present form, create substantial uncertainty. HCFA should take two actions suggested below to correct this problem in the final rule.

HCFA has asserted that its regulation is needed to stem a growing "medical arms race," where technology is irresponsibly purchased and used. If there is such a phenomena, we doubt that HCFA's rule would help because it does not impact the unregulated portion of the health community—physician offices. The hospital capital payment policy may present an opportunity for physicians, with the encouragement of manufacturers, to purchase and utilize their own high technology equipment.

MAJOR RECOMMENDATIONS

First, protect vulnerable hospitals. The hospital community has put forward the concept of a permanent exceptions process that would guarantee each hospital having a capital cost per discharge above the Federal payment level, that it would be paid under the Administration's capital payment methodology no less than 80 percent of its capital costs. CHA supports this concept.

Second, assure predictability of Medicare hospital revenues important to create an environment that will enable hospitals to legitimately renovate and replace existing facilities and to assure access to new technology of proven benefit to Medicare patients. This does not imply that hospital system capacity remain unchanged, but that renovation and replacement of facilities occur, when appropriate, to respond to changing community needs and conditions. In this regard, HCFA's proposed rule provides insufficient specificity as to the permanent update methodology to be implemented after FY 1995. This causes great uncertainty.

To reduce this uncertainty and to restore predictability to the capital payment methodology, *CHA believes that HCFA should incorporate an update methodology into the final rule that will, after FY 1995, provide annual increases in the standard Federal payment rate that are based on the actual increases in capital costs.* In no case should these be lower than the annual updates HCFA asked the hospital community to rely on in its computer diskette software, "Capital PPS Payment Worksheet."

SPECIFIC PROBLEMS IN THE NPRM AND RECOMMENDATIONS

In addition to our overriding concern with the proposal, there are a large number of policy issues with the proposed regulation that need to be addressed.

Old Capital

The NPRM establishes a definition of "old capital costs" for purposes of the hold harmless provision. The definition includes allowable Medicare inpatient depreciation and interest expenses for capital assets used for patient care and reported on the hospital's Medicare cost report for the latest cost reporting period ending on or before September 30, 1990. There are three problems with this definition:

- *Definition:* The limitation of the definition of capital to interest and depreciation expenses for assets used for patient care unduly restricts Medicare's current definition of capital costs to some but not all old capital, and changes the understanding under which hospitals have operated in good faith since the inception of the Medicare program;
- *Commitments:* The need to have assets in place and used for patient care in order to qualify does not recognize the many stages and variations of the capital commitment process.

• *Cut-off Date:* The FY 1990 date itself is far too retrospective, and basing the cut-off date on the last day of a hospital cost reporting period puts too many hospitals at an unnecessarily unfair advantage.

Limitation in definition of capital

The definition limits old capital to interest and depreciation expenses for capital assets used for patient care. The problem is that the definition excludes a number of costs that are currently included in Medicare's definition of capital costs. Among the items excluded are lease arrangements, rental agreements, insurance, taxes, licenses, royalty fees and related organization capital-related costs for assets that are not maintained on the premises of the hospital but are filed in the home office cost report of the appropriate multi-hospital system. It is not clear to us why some but not all capital costs are included in the definition of old capital and thus subject to the hold-harmless definition.

CHA strongly urges the use of Medicare's existing definition of capital in defining old capital. This is consistent with ProPAC's recommendation.

Failure to Recognize the Various Stages of Commitment to Capital Projects

A second element of the problem of the proposed definition of capital costs is that it requires the assets to be in place and used for patient care as of a certain date in order to meet the definition of "old capital costs." This definition ignores the underlying realities of the capital planning and implementation timetable. It takes time (years in the case of construction) for a hospital to plan and implement a capital project to the point where assets are in place and used for patient care. CHA, for example, estimates that it takes 3-5 years for a project to move from initial decision to "assets in place." The point at which a hospital commits itself to the completion of a capital project will vary from one project to another as well as from one hospital to another. No two hospitals or projects follow exactly the same path to establishing such commitments.

There are a number of examples of the type of commitments that are excluded by the NPRM.

• Hospital and board decision and commitment: following extensive analysis and review (an expensive process to begin with), hospitals make final decisions and commit to capital projects and initiate steps to proceed. Yet, despite these decisions, projects so committed will not be included as "old capital."

• Feasibility study; hiring of an architect: following an initial decision, hospitals engage in feasibility studies, and hire architects to develop plans. Yet despite these commitments before the cut-off date, the projects resulting from these actions would not be considered "old capital."

• Bond issues: Hospitals have already initiated capital funding and/or gone to the capital markets to raise funds for future capital projects, sometimes financing a future estimate of a multi-year capital plan through one bond issue. This can be a means of locking in favorable interest rates, and avoiding the expensive costs of multiple fees for multiple bond issues—a management efficiency that is presumably to be commended, not penalized. Yet despite this preexisting commitment, the capital assets financed with this form of commitment is not considered "old capital."

• Lease agreement or purchase agreement signed: Hospitals make commitments to purchase or lease equipment or facilities well before the asset is in place. These are binding commitments—yet they are not included within the definition of old capital.

• Construction-in-progress: hospitals often have construction in progress—although again, the asset is not yet in place. Again, this is the type of obligation that must be included in any definition of "old-capital."

Since this regulation is dealing with commitments that have been made in the past, *it is necessary to broaden the proposed rule's definition of capital commitment.*

CHA recommends that if a hospital has progressed to the point that a capital cost has been incurred in the process of completing a capital project, then that project must be considered "old capital" for purposes of the regulation. If any of the above types of commitment has occurred (i.e., a binding hospital decision, feasibility study or architect engaged, a bond issue floated, a purchase or lease agreement signed, construction in progress, or any other type of capitalizable cost is incurred) then the commitment or obligation has begun, and that capital project should fall within the definition of old capital.

Cut-Off Date

Finally, the cutoff date requires that an asset be used in patient care for each hospital's FY 1990 cost report. This is far too retrospective a cutoff date, and the use

of a hospital's cost reporting period places too many facilities at an unnecessarily unfair advantage. The cut-off date should be the same date for all hospitals. For proper information and planning in this all-too-uncertain field, *CHA recommends that the cutoff date should be the publication date of the final regulation.*

PAYMENT ADJUSTMENTS

There are numerous problems with the adjustments used in the proposed payment policy.

Use of Case Mix Index (CMI)

The NPRM uses the hospital case mix index (CMI) to adjust capital costs per case for some components of the proposed capital payment system. However, CHA shares the concerns of the AHA about the appropriateness of this use of the CMI.

HCFA's own analyses in the NPRM indicate that for hospitals with fewer than 100 beds, the use of the case mix adjuster would be inappropriate because it would underpay these hospitals. And the AHA disputes HCFA's analyses for hospitals with more than 100 beds. The AHA has found that the CMI does not adequately adjust for case mix in these larger hospitals: hospitals with high case mix would be underpaid relative to other hospitals. Thus, *CHA believes that it is clear that the current CMI is not an adequate proxy, and revisions must be developed and reviewed carefully in order to assure that this payment adjuster more accurately accommodates differences in capital costs attributable to case mix.*

Disproportionate Share Provider Payment Adjustment

The NPRM establishes a definition of disproportionate share hospitals and services under the regulation that differs from that under PPS: it limits disproportionate share hospitals to facilities with more than 100 beds, rather than including all of the disproportionate share hospitals (including those of fewer than 100 beds) under PPS. Thus, current disproportionate share facilities with fewer than 100 beds are excluded.

CHA, like ProPAC, recommends that the disproportionate share definition be the same as that used under the PPS system.

Outliers

The proposed rule treats capital-related day outliers in the same manner as operating day outliers. Capital payments for cost outliers would be made only when both the capital and noncapital costs exceed the cost outlier thresholds.

CHA is concerned that there is no guarantee that amounts withheld from the payment rate for the outlier pool will be fully paid. *CHA recommends that any amounts not paid out be automatically added to the standardized rate for subsequent years, and that those amounts be defined as part of the budget "baseline."*

Capital Cycle

One of the fundamental problems with incorporating capital into an administered pricing system such as that proposed is that capital costs vary significantly along the capital cycle. The PPS model and adjustment process can account for some of the variability in costs related to the case—but the timing and financing of buildings and equipment is an equally important variable in capital payments. In fact, the NPRM states that:

> "The most important factors that would determine the impact of the proposed capital prospective payment system on an individual hospital are the timing and amount of its capital expenditures."

Yet, the regulation does not provide for any adjustments for the all-important capital cycle (other than the 10 year transition).

Another problem with folding capital into a prospective payment system is that hospitals differ significantly in their leverage ratios. Unique hospital characteristics require them to borrow at different levels, rates, and lengths of time. But again, the proposed rule would not include an adjustment to payments for this critical factor.

The CHA believes that if capital costs are to be included in an administered pricing system, then that system must account for the key factors underlying variability in costs—namely the capital cycle and leverage. *CHA recommends that the payment system be revised to include an equitable capital cycle and leverage adjustment factors.*

"Hold-Harmless" and Exceptions

The hold harmless provision is provided for hospitals whose hospital specific rate is higher than the FY 1992 adjusted Federal rate. Hospitals under the hold-harmless methodology would be paid the higher of the following two payments:

- Old capital plus new capital method: hospitals would be paid 90 percent of the old capital costs, plus a proportion of new capital costs; or
- The Federal rate: hospitals would be paid 100 percent of the Federal rate.

The problem with the provision is that the "hold-harmless" is not a hold-harmless. In fact, we have found numerous instances where a hospital required to use the hold harmless would be better off financially under the fully prospective methodology—but cannot qualify since it must move to the hold harmless methodology. That presents an extremely unfair situation: because a hospital's hospital-specific capital costs are higher, it must go to the hold-harmless methodology instead of the fully prospective methodology. Yet that so-called "hold-harmless" methodology ends up being more harmful than the fully-prospective rate from which they are presumably being protected.

The exceptions process sets out two complicated arrangements for dealing with some of this problem of capital costs far in excess of the payment rate. One exception is for hospitals whose capital costs in FY 92 exceed 150 percent of the payment under the proposed regulation. The second is for rural sole community hospitals, and urban hospitals with more than 100 beds and a disproportionate share percentage of at least 30 percent. In each case, hospitals receive certain percentages of their capital costs in excess of the certain payment thresholds.

The CHA believes that a third alternative payment methodology must be included as a permanent exception and true "hold-harmless" under which capital payments under the proposal could in no case be less than 80 percent of actual capital costs. In addition, hospitals should have the opportunity to use the fully prospective rate if it is higher than any of the "hold harmless" methodologies.

Exceptions Pool

The NPRM sets aside a 10 percent exceptions pool to fund the exceptions payments during the course of the ten-year transition.

The CHA has two concerns with this pooling arrangement. First, the upper limit of 10 percent means that the exceptions thresholds will not be predictable—compounding the uncertainty about the amount of payment under the regulation. Second, the CHA is concerned that the amount withheld for the pool may not be spent. *CHA recommends that if the pool is not fully spent, the excess amounts be built into the standardized rate in subsequent years, and that those amounts be considered part of the budget baseline.*

Another problem with the exceptions authority is that it appears to expire after ten years; the CHA recommends that it be extended beyond that point. If it is not extended, or is extended but at less than 10 percent, then any amounts not included in the exceptions pool must be restored to the base rates and considered as part of the budget baseline.

Update Factor

The proposed regulation provides for annual updates in the standard Federal payment rate.[1] From FY 1992 through FY 1995 the annual updates are based on projected increases in Medicare capital related cost per discharge occurring two years earlier, adjusted for downward increases in case mix and further adjusted for changes in the exception pool reduction factor and the budget neutrality factor.

With respect to a permanent update methodology to be implemented in FY 1996, the preamble to the proposed regulation states that:

> " . . . beginning in FY 1996, we propose to determine the update through an analytical framework that would take into consideration increases in the capital market basket and appropriate changes in capital requirements resulting from new technology and other factor, such as changes in occupancy rates."

Indications are that HCFA is 18 to 24 months away from completion of a permanent update methodology.

It should be noted that HCFA recently distributed a computer software model and asked hospitals to use the model to evaluate the impact of its capital proposal on them through the transition period.

---

[1] Standard Federal payment rate = $471.54.

HCFA incorporated into the model, (but not so they could be identified by the user hospital), the following assumptions about the annual update of the standard Federal payment rate after FY 1995. These are:

FY 1996	3.1%
FY 1997	5.4%
FY 1998	5.2%
FY 1999	5.5%
FY 2000	5.7%
FY 2001	5.7%
FY 2002	5.7%

These updates are based on HCFA's projections for increases in capital cost per discharge through FY 1995 adjusted downward by 2 percent to reflect HCFA's estimate of annual increases in case mix, then trended forward through FY 2002.

HCFA asked the hospital community to *rely* on these HCFA offered assumptions when making their judgments about the impact of its capital proposal; and most hospitals have done so.

It is impossible to assess the implications of the proposed regulations if out-year update factors are not spelled out. *CHA recommends that if HCFA is to proceed with the idea of a change in capital payments then those out-year update factors, along with other changes noted above, should be spelled out as part of a revised proposal for careful review and analysis.*

CHA believes that HCFA ought to remove the uncertainty associated with this crucial part of its proposal. It can do this the actual increases in capital costs. In no case should these be by incorporating into the regulatory language of the final rule an update methodology that will, after FY 1995, provide annual increases in the standard Federal payment rate that are based on lower than the annual updates HCFA asked the hospital community to rely on in its computer diskette, "Capital PPS Payment Worksheet." In order to insure this, the updates HCFA provided in its "Capital PPS Payment Worksheet" should be written into the final rule as a level below which the annual update could not fall.

CONCLUSION

It is important to note again that CHA applauds HCFA's process of extensive consultations, and we appreciate the efforts to address the complexities of hospital financing in crafting this regulation.

However, we are not satisfied with HCFA's response, so far, to the concerns raised by hospitals, their leaders, by ProPAC and by others concerned and knowledgeable about the potential damage that can result from implementation of this rule.

A key fact for the Subcommittee is that there is no urgency for change at the present time because **the constraints of the private payor and prospective payment system (PPS) have already limited the rate of increase in capital spending—this important policy objective has already been achieved.**

The Subcommittee should also understand that numerous *technical problems remain:* the nature of capital financing is substantially different from operating costs, and applying the PPS paradigm with adjustments simply does not work. While HCFA has addressed some areas in the regulation, the problems that we identified above with the possible exception of "old capital" remain to be addressed. Over time, additional complicating adjustments will be required to make the formula workable. And these adjustments will yield a regulation which inevitably will be so complex as to be virtually incomprehensible. It will still result in a painful redistribution of funds with little justification.

Thus, with no pressing urgency for change, time can be taken for the additional efforts which are required. CHA concludes that the proposed regulation requires substantial additional work on the issues identified, and that HCFA should be given an extension of the proposed rules effective date pending the completion of that work.

The nation's Catholic hospitals stand ready to work with the Senate Finance Subcommittee on Medicare and Long Term Care, the Health Care Financing Administration and other interested parties to fashion a fair and equitable Medicare inpatient capital payment policy.

PREPARED STATEMENT OF GAIL R. WILENSKY

Mr. Chairman and Members of the Committee: I am pleased to be here today to discuss the Administration's proposal to implement a prospective payment system for inpatient hospital capital costs.

INTRODUCTION

Cost-based reimbursement for Medicare capital is inherently inflationary, contributes to the escalating cost of health care, and improperly distributes health care dollars. The current system of distributing capital dollars props up idle capacity, contributes to a technological "arms race," and drives up operating costs and physician spending. Those who argue that the current cost-based system for capital is not a problem are just plain wrong: the capital payment system needs to be changed now.

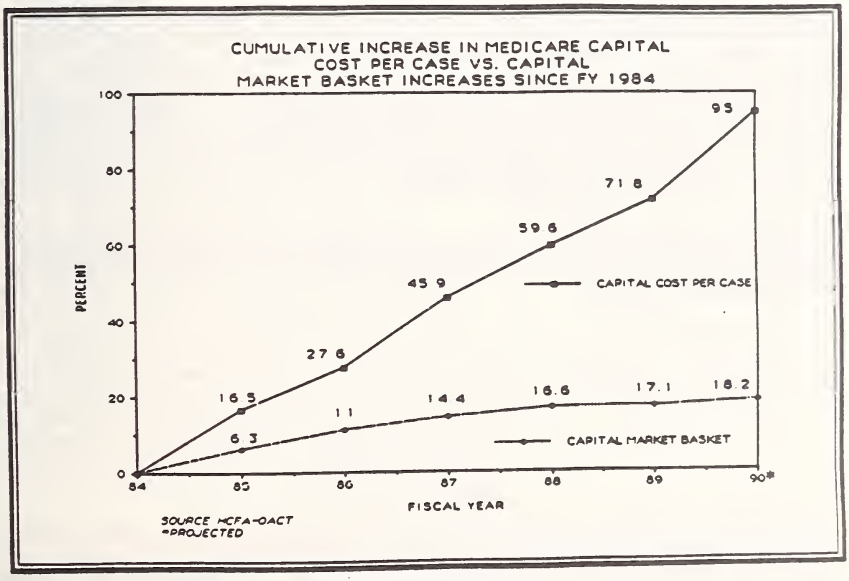
Our proposal to implement a prospective payment system for capital is an important step toward curbing inappropriate spending. A capital prospective payment system provides the incentives to practice prudent decisionmaking. While this proposal will not cure health care inflation by itself, it is a move in the right direction.

Moderating the growth in health care costs is a must if we are ever to address the broader issues of health care reform. I hope you will Join me in supporting this change.

MEDICARE CAPITAL SPENDING

Medicare capitol expenditures are growing at an unacceptable rate. The rate of growth in Medicare capital spending is twice that of overall inflation. Chart 1 compares the relative growth in hospital capital costs to the growth in the hospital capital market basket. Since 1984, the cost per case for hospital capital has increased almost 100 percent, while capitol input prices have grown less than 20 percent. The chart indicates that volume and intensity of capital acquisition far outpace the increase in input prices for capital assets.

CHART 1



THE CURRENT SYSTEM

The current cost-based system for Medicare hospital capital payments is unfair to all hospitals and encourages wasteful spending.

Penalizes Prudent Hospitals

Under current law, Medicare pays hospitals 15 percent less than its share of costs. Medicare capital payments under the current system have been restrained only through progressively deeper cuts. In 1986, Medicare reimbursed at 100 percent of reasonable costs; in 1987, 93 percent; in 1988, 88 percent; and in 1989 through 1991, 85 percent. Continued cost control is likely to require even deeper cuts. Discounted payments penalize all hospitals, particularly those that make prudent capital decisions.

Perpetuates Inefficiencies

Cost reimbursement provides no incentive to control capital spending. Medicare pays the same share of costs for prudent capital investment as it pays for an unnecessary luxury or inefficiently used resources. Medicare pays for capital regardless of how expensive or necessary the equipment, how underused the plant, or how high the interest rate for borrowing. In effect, the more hospitals spend, the more Medicare pays.

The conflicting payment systems now in place for operating costs (prospective payment) and capital costs (cost reimbursement) distort the normal business environment. Payment of actual costs encourages overcapitalization, such as the purchasing of equipment, instead of making more efficient arrangements to provide services.

Maintains Underutilized Facilities

Between 1984 and 1988, hospital inpatient admissions declined 2.7 percent annually while total inpatient capital costs have increased 9.2 percent each year. Today, over one-third of all hospital beds in this country are empty. Reimbursing hospitals to maintain underutilized facilities provides no incentive to downsize or convert to alternate uses even when such actions are clearly justified.

Cost-based reimbursement continues to subsidize excess capacity because payments are unrelated to Medicare admissions. Instead, Medicare payments are based on the proportion of Medicare patient days of care provided by the hospital. With declining admissions and occupancy, Medicare patients use an increasing proportion of total hospital inpatient days. For example, one 273 bed hospital had a total occupancy of only 36 percent, three-quarters of which were Medicare patients. As a result, Medicare paid 74 percent of all the hospital's capital costs, including funds necessary to maintain the unused capacity—two-thirds of the hospital's beds.

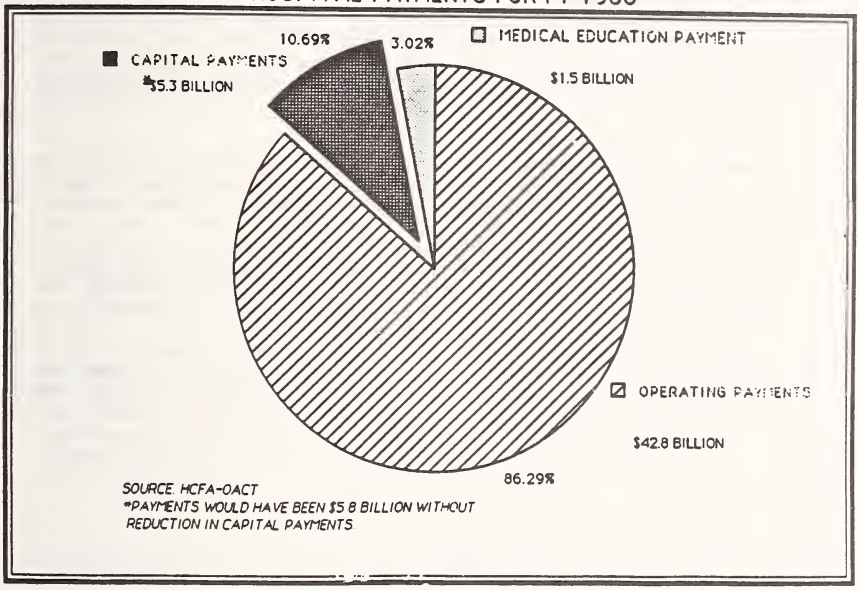
The incentives in the current system give a green light to capital spending projects of marginal value. For example, one hospital added a 71 bed satellite facility. Because of the expansion, its total capital costs increased 90 percent. At the same time, Medicare patient days decreased 6 percent. The Medicare program should not continue these unjustified subsidies.

Drives Up Operating and Other Costs

As Chart 2 indicates, the lion's share of Medicare hospital payments are made for operating expenses. Capital payments represent about 10.7 percent of Medicare's overall inpatient payments.

CHART 2

TOTAL MEDICARE INPATIENT
HOSPITAL PAYMENTS FOR FY 1988



However, it is important to note the effect capital expenditures have on operating costs. The acquisition of new technology drives up operating costs for staffing and other support services.

Technological advances have led hospitals to participate in a medical "arms race" as they strive to remain competitive. For example, the General Accounting Office confirmed a situation where one hospital and a group of radiologists each purchased MRI machines, despite the availability of an MRI in the next county. As a result, a small area has three sophisticated and costly diagnostic machines. With these machines, physicians apparently performed more MRI scans per resident than were done in one of the major cities in the State.

Although hospitals purchase capital equipment, it is the physicians who bill Medicare and other payers for the services they provide using that equipment. Unnecessary capital acquisition drives up overall health spending and all payers—business, government, and private insurers—foot the bill.

We have heard hospital representatives acknowledge that Medicare's capital reimbursement policy encourages careless spending. In one example, the purchase of a new computer system by one hospital group was not thoroughly investigated in terms of its size relative to future plans for expansion. The company conceded that a "what-if" analysis to consider the downside risk was not performed because the costs were fully reimbursed by Medicare. This behavior is specifically what a capital prospective payment system is designed to change.

PROSPECTIVE PAYMENT

When PPS was enacted in 1983, Congress intended that capital be included in the new system. The Omnibus Budget Reconciliation Acts (OBRA) of 1986 and 1987 temporarily blocked regulations to do so, but continued to require the eventual implementation of a capital PPS. In OBRA 1987, Congress mandated that a capital PPS be implemented on October 1, 1991.

Prospective payment for capital will address the inequities and inefficiencies of cost-based reimbursement and provide hospitals the incentives to make prudent capital investments.

Continues to Finance a Modern Well Equipped Hospital Industry

Medicare spending on hospital capital will continue to finance a modern well-equipped hospital industry because Medicare capital funding will not be cut. In fact, aggregate Medicare capital payments will increase from 85 to 90 percent of reasonable costs, a 5.9 percent increase.

Capital PPS will foster economic incentives for sound business decisions on capital investments. Hospitals that plan appropriately and invest wisely will be able to remain up to date and well equipped. The proposed regulation will compel hospitals to better plan how they can provide cost-effective, quality health care. This change is long overdue.

Provides Predictable Payment

The prospective payment system establishes a payment rate that recognizes the capital costs necessary for hospitals to manage their capital programs efficiently. Under the new capital payment policy, hospitals will receive a fixed payment amount for each Medicare patient they serve. Hospitals will be able to plan their expenditures responsibly because the payments will be predictable.

In addition, OBRA 90 provides a stable budget baseline through FY 1995. Finally, the proposed regulation specifies full actual cost updates to the Federal rate through FY 1995. Between now and FY 1995, we will work with the industry to develop an acceptable methodology for future updates.

There seems to be considerable concern within the hospital industry that capital PPS is just another system designed to ratchet down costs, particularly after 1995 when the updates cease to be specified in law. This is not our intention. Capital PPS will provide a consistent system of payment for capital. If our primary intent were to simply reduce Medicare capital spending, this could have easily been accomplished by deeper discounts on the current cost-based system. Our goal, however, is to develop a payment system with incentives for sensible spending, consistent with a hospital's workload.

Is Consistent With Congress' Broader Message

Congress has repeatedly and consistently called for payment reforms that move away from cost-based reimbursement. The Medicare program is moving steadily toward prospective payment for a broad range of services. Research and demonstrations are actively exploring prospective payment for ambulatory care services, nursing homes, and home health care. Prospective payment for capital is an important step in continuing necessary payment reform.

GETTING FROM HERE TO THERE

Prospective payment is a simple concept. However, moving from cost reimbursement to a prospective system requires a careful approach to avoid financial disruption and ensure fair treatment of hospitals in differing situations.

Before developing our capital proposal, we consulted extensively with the hospital industry, the investment community, members of Congress, and others. Since publication of the proposed rule in February, we have continued a productive dialogue with interested parties. These discussions reaffirmed our desire to offer a reasonable amount of protection as hospitals move into the new capital prospective payment system.

Transition Period

To ease hospitals into the new system, the proposed rule provides a generous ten-year transition to a fully Federal rate. During the transition, two types of payments will be made to hospitals depending on their current capital obligations:

Method 1: "Hold Harmless" Protection for Old Capital Obligations

Hospitals with existing capital commitments above the national average would be paid through a "hold harmless" payment methodology. These hospitals would receive 90 percent of their costs for "old" capital plus a payment for new capital costs.

Method 2: Fully Prospective Payment for Hospitals with Low Capital Costs

Hospitals with capital costs below the national average would be paid a fully prospective payment rate based on a blend of their hospital-specific rate and the Federal rate. For FY 1992, the payment blend would be 90 percent of the hospital-specific rate and 10 percent of the Federal rate. Over the ten-year transition period, the Federal portion of the payment would increase by 10 percentage points each year, while the hospital-specific portion would decrease by the same amount.

Hospitals with low capital costs would be helped because they would receive payments based on an increasingly larger proportion of the Federal rate. We estimate

that over 95 percent of hospitals which currently have low capital costs would gain under the proposed rule, with 52 percent gaining more than $100 per case. This additional payment can be put towards future capital needs.

Hospitals that tend to have low capital costs include rural hospitals, sole community providers, and government-operated hospitals. Because approximately 75 percent of rural hospitals are low cost, they would generally gain under our proposed capital regulation. Rural hospitals would receive higher payments than under the current cost-based system.

Similarly, approximately 70 percent of sole community hospitals will receive higher payments under the proposed capital regulation than they would under cost-based reimbursement, if they maintain their current spending patterns.

For both payment methods, adjustments to the Federal rate would be made to account for each hospital's case mix, geographic location, and the higher costs experienced by certain hospitals that treat a disproportionately high number of indigent patients. Additional payments would also be made for extraordinarily costly or lengthy cases.

Exceptions Process

Most hospitals will be able to live within the basic capital payments provided under the regulation. However, we recognize that certain hospitals have refrained from major capital improvements and have a genuine need to upgrade their facilities. These hospitals would receive an exceptions payment. Additional payments would also be provided to urban hospitals which serve a large proportion of low-income patients. Rural sole community hospitals that need to undertake major capital projects during the transition period are eligible for exceptions which will provide more generous payments.

Under our proposed regulation, financially-troubled rural sole community hospitals that serve a large proportion of low income patients and certain urban hospitals would receive an exceptions payment of 75 percent of capital costs in excess of 100–125 percent, on a sliding scale, of Medicare capital payments. The amount depends on the size of the current capital costs relative to the hospital's hospital-specific rate. This exceptions policy recognizes the special need to maintain access to care in more isolated rural areas.

A PARTICIPATORY PROCESS

We made significant efforts to encourage participation in the rule-making process. We provided information and briefing materials on our proposed regulation to every member of the House and Senate to further their understanding of this complex regulation and enable them to address their constituents' concerns.

We have had frequent and extensive meetings with representatives of the hospital industry. We provided every Medicare participating hospital with a computer disk and a manual worksheet to enable them to analyze the impact of our proposal on their facilities.

We also extended the comment period an additional 15 days to provide more time for hospitals to better understand the proposal and present their comments for our consideration.

Major Comments

We are now carefully analyzing the comments as we develop the final rule. The comments raise several legitimate concerns and we will address them in a budget neutral fashion. We believe some modifications are warranted and we are currently reviewing options we can use to refine the proposed regulation. We plan to publish the final rule on August 30.

The most frequent comments fall into two categories: the definition of "old" capital and the exceptions process. Many commenters recommend expanding the definition of old capital to include leases, home office costs, taxes, and insurance. Many also recommend establishing a cut-off date for old capital to include more recent capital projects or obligated capital that has not yet appeared on the cost report.

We requested that commenters provide specific suggestions on our definition of old capital and ways to broaden the definition of obligated capital. We are analyzing the suggestions to determine if an alternative definition can be developed that is fair and equitable. Changes of this nature, given the requirement for budget neutrality, might result in a balance of payments different from current estimates. We are carefully examining the technical issues surrounding these recommendations.

Commenters also recommend an exceptions policy that does not use Medicare margins in determining exceptions for sole community hospitals and certain urban hospitals. Many recommend that there be a permanent exceptions policy. Some see

the need for a more flexible exceptions policy that would allow for determinations of exceptions due to extraordinary circumstances. Others prefer to substitute a payment floor for an exceptions policy.

We also received many comments on the adjustments to the Federal rate especially for case mix, disproportionate share, the addition of a medical education adjustment, the use of the hospital wage index as a proxy for variations in construction costs, and a more generous adjustment for urban hospitals serving low income patients.

We are carefully evaluating these comments using fiscal year 1989 data. These more recent data were not available in February when we were developing the proposed rule. We have also expanded our sample of hospitals for which we have age and financing data available, to more than twice the number of hospitals available during development of the proposed capital regulation. We will use this FY 1989 data to more accurately evaluate each hospital's capital costs and apply this assessment to the development of the final rule.

The Prospective Payment Assessment Commission (ProPAC) has also provided recommendations on our proposed regulations, as required by Congress. I am pleased that ProPAC agrees that capital should be paid on a prospective basis beginning October 1. We are giving their recommendations full consideration in developing the final regulation.

We are engaged in an open dialogue with ProPAC regarding questions relating to the assumptions and equations used in our capital modeling and other analyses. We continue to provide information requested by ProPAC and the American Hospital Association. We understand the importance of addressing concerns about the validity of our estimates and rate calculations to ensure public confidence in this regulation. We will continue to address these specific issues to ensure a fair and equitable capital payment system.

CONCLUSION

We will closely monitor the effect of the capital regulation on hospitals following its implementation, and welcome the ongoing involvement of hospitals, ProPAC, and others. We know that, despite our best efforts, the final regulation will not be perfect. Once experience is gained, some fine tuning may be required.

The proposed prospective payment system for capital will adequately compensate hospitals that make wise investments and provide quality care. Our proposed rule balances the needs of hospitals to provide effective and efficient care with the need to practice fiscal responsibility.

The task before us is to implement prospective capital payment. Our extensive efforts over the past year, as well as those we have underway to develop the final regulation, will produce a solid prospective payment system for capital.

RESPONSES OF GAIL R. WILENSKY TO QUESTIONS SUBMITTED BY SENATOR MOYNIHAN

Question No. 1. Hospitals that get hurt fall into three categories depending on their position in the capital cycle.

A. Several hospitals are in the middles of major construction projects or finished after the deadline.

Will you extend the hold harmless provision to include these hospitals so that they don't default on mortgage and other obligations?

B. Several hospitals have not yet begun to build but have spent millions on planning, architectural, engineering and other costs. They would have been further along, but for the State approval process, which delays construction in order to ensure project worthiness.

Will you extend the hold harmless provision to include them?

C. Several hospitals have not yet invested in major modernizations but have received board approval to initiate the process. If they are not provided adequate Medicare funding they will not be able to proceed, which will reduce access to state of the art health care for their overburdened communities.

Will you extend the hold harmless provision or provide exceptions payments to cover these hospitals?

Answer. We are currently developing the final capital regulation in consideration of the comments received during the public comment period. All the issues and concerns raised in your questions have been raised in the comments and are being analyzed and carefully considered.

1. In the proposed rule, we specifically requested public comments on our definition of old capital and alternative suggestions that would broaden the definition to include obligated capital, including projects in various stages of planning.

We have received many detailed comments regarding extension of the hold harmless provision for those hospitals that have not yet completed their capital projects. We are currently analyzing the suggestions received and will continue to consider such changes. We are also looking into some modifications for those hospitals who are in various stages of planning to undertake a capital project but have not yet begun construction. We have received many detailed comments suggesting definitions of binding contracts for obligated capital costs. These are some of the ideas we are considering to refine the definition of obligated capital.

Question No. 2. I understand that if the need for hold harmless and exceptions payments exceeds the amount of funding set aside for these payments, HCFA plans to reduce hold harmless and exceptions payments. Since this would unduly harm the hospitals that need assistance the most, will consider paying for the excess by reducing all Medicare payments to "spread the pain?"

Answer. For FY 1991-1995, the law requires that total capital payments must be budget neutral at 90 percent of what would have been paid under the previous system. If estimates of annual capital spending exceed a budget neutral amount, reductions would be made to the Federal rate, the hospital-specific rate and "hold harmless" payments necessary to maintain neutrality.

We have proposed that exceptions payments not exceed 10 percent of total capital payments. We believe that it is appropriate to cap exceptions payments. Therefore, if estimates indicate that exceptions payments would exceed the 10 percent level, it would be necessary to change the threshold for exceptions payments.

Question No. 3. There is a provision that requires special exceptions payments to be offset by the amount that non-capital Medicare payments exceed non-capital Medicare costs. This is inappropriate because such "surpluses" are due to efficient operations as well as Congressionally mandated subsidies of non-Medicare costs for high disproportionate share and teaching hospitals. Will you eliminate this provision?

Answer. The point you have made is well taken and careful consideration is being given to the exceptions offset provision you have inquired about.

Question No. 4. Will you consider the following technical changes?

A. HOLD HARMLESS PROVISION

• The definition of old capital should include leases, rentals and all other currently reimbursable Medicare capital costs.

• The transition period should be extended from 10 to IS years to reach the average crossover point for mortgage payments.

B. FEDERAL RATE

• A construction cost index should be used rather than an index adapted from the area wage index.

• The PPS disproportionate share formula should be used instead of the one now being proposed for capital because the operating and capital disproportionate share adjustments should be consistent. In addition, the PPS formula appropriately includes a higher adjustment for hospitals with the greatest percentage of disproportionate share patients.

• The PPS indirect teaching adjustment should be applied to the capital reimbursement rate because capital requirements are affected by a hospital's teaching status.

C GENERAL

• change the base year from 1989 to 1990 for New York State hospitals in Order to reflect the most current costs.

D. SPECIAL EXCEPTIONS PROVISION

• Lower the qualifying disproportionate share threshold from 30% to a level closer to 20.2%, which is the level that triggers the highest DSA reimbursement in the PPS formula.

Answer. A.—We have received the most comments on issues concerning the definition of old capital. We had specifically solicited comments on this definition and were helped by recommendations put forward by various industry and advocacy groups. We realize that our proposed definition may have been too narrow. We are considering such comments as we develop the final rule.

—We believe that the ten year transition period is adequate as originally proposed. However, if it appears, toward the close of the transition, that an extension may be warranted, we will be open to consideration of options to do so.

B.—We believe that the area wage index is the better predictor of capital costs than the construction cost index. However, we are not opposed to creating a new index when better data are available for our use.

—We are currently considering whether more recent data justify a different DSH adjustment for the final rule. There have been several comments on this provision and we are taking them under advisement.

—Again, we are analyzing more recent data to determine whether an IME adjustment is warranted.

C. In response to your question about the base year, our proposed rule uses 1990 as the base year for all hospitals.

D. We are considering comments to bring the DSH threshold closer to that used on the operating side.

Once the final rule is published, the capital prospective payment policy does not become static. We will continue to examine our projections and make revisions based on more recent data and refined estimates. As the payment adjustments are updated annually, the opportunity to identify any shortcomings and make corrections to the capital payment system can be exercised.

PREPARED STATEMENT OF DONALD A. WILSON

Mr. Chairman, my name is Donald A. Wilson, President of the Kansas Hospital Association. On behalf of KHA's over 150 member institutions, I am pleased to testify on the proposed prospective payment system for Medicare inpatient capital costs. This regulation affects both the urban and rural hospitals in Kansas significantly, however, I will focus primarily on the rural issues during this testimony. The recommendations of the Prospective Payment Assessment Commission (ProPAC), and the American Hospital Association with regard to urban hospital issues are, however, strongly supported by KHA.

ABOUT KANSAS HOSPITALS

The citizens of Kansas and surrounding States are served by 167 hospitals, of which 138 are considered community hospitals. Sixty-three of those 138 hospitals are non-governmental not-for-profit, 67 are owned by a governmental unit (city, county or district), and 8 are investor owned. The remaining 30 hospitals are either Federal, psychiatric, or other non-community/non-governmental types of hospitals. Twenty-two of the hospitals are located within one of Kansas' four SMSA's, while the balance of 116 hospitals are considered rural. Ten of the eleven hospitals with more than 300 licensed beds are located in urban areas.

It has been projected that Kansas will experience a 17% increase in the number of people over the age of 65 by the year 2000. Despite this "graying of Kansas," Medicare utilization has steadily declined. Medicare discharges for 1989 were 109,990 as compared to 140,397 in 1982, a 22% decrease since the inception of PPS. This commitment by Kansas hospitals to a more cost-effective level of treatment was brought about by several factors including, enhanced delivery of out-patient services, effective discharge planning and case management, technological advances, and changes in utilization patterns by physicians.

The continued delivery of quality health care in Kansas is rapidly becoming tenuous. A total of 69 counties were determined to be medically underserved by primary care physicians in 1990. Of the 69 counties, 51 were determined to be critically underserved. Additionally, inadequate updates to payments from programs such as Medicare, Medicaid, Blue Cross, Workers Compensation, and managed care organizations have not been sufficient to keep pace with rising operational and technological costs experienced by hospitals. This is particularly evident for rural hospitals.

Rural hospitals differ from urban hospitals in many ways. KHA research indicates that rural facilities are significantly older than their urban counterparts, thus increasing their need for an equitable and predictable capital payment system from Medicare. Also, they provide a higher percentage of outpatient services, generally treat an older patient mix, and according to the American Hospital Association, treat a larger percentage of uninsured patients than their urban counterparts.

Additionally, in their report titled "Rural Hospitals, Federal leadership and Targeted Programs Needed" (June, 1990), the GAO concluded that rural hospitals face the following problems:

- Low patient volume and resultant higher costs per discharge;
- Less ability than urban hospitals to compete for patients and physicians;
- Limited patient and non-patient revenue; and

- Burdensome regulatory constraints.

Rural Health Networks

In testimony before the Committee on Ways and Means, Subcommittee on Health, of the U. S. House of Representatives, HCFA Administrator Gail Wilensky stated that "reimbursing hospitals to maintain underutilized facilities provides no incentive to downsize or convert to alternate uses. In Kansas this simply is not true.

Provisions in the 1989 and 1990 Omnibus Budget Reconciliation Act established and funded the EACH concept. A public/private partnership between KHA and the Kansas Office of Rural Health has been studying the benefits of this concept for our State. It appears that the benefits will be significant, especially the financial incentives for hospitals to form rural health networks.

Essentially, the EACH concept is a program which designates, on a voluntary basis, very small rural hospitals as Rural Primary Care Hospitals or RPCHs (pronounced "peaches") that are linked with larger supporting hospitals designated as Essential Access Community Hospitals or EACHs. Together with other hospitals and health care providers, the participants form a regional network to provide access to quality services in a cost effective manner.

During the Federal grant application process in the spring of 1991, 24 Kansas community hospitals and one Oklahoma hospital organized into eight rural health networks which included 17 potential RPCHs, six potential EACHs and two non-EACH supporting facilities. Eleven other hospitals are also members of these networks but do not intend to change their current services or delivery mode. These Kansas facilities have worked hard to position themselves to implement the EACH concept once Federal regulations are promulgated.

GENERAL CONCERNS

The Kansas Hospital Association strongly opposes the development of a prospective payment system for Medicare inpatient capital costs as proposed and has serious reservations concerning the detrimental long-range financial ramifications to Kansas hospitals should the rule be implemented as proposed.

Regarding the implementation of the proposed system, KHA believes that it will be costly and cumbersome, both to the Federal government and to hospitals. New and additional costs to the Medicare program would be incurred for fiscal intermediaries to calculate hospital-specific rates at the outset and the conducting of detailed audits of hospitals' capital costs each year, as well as the hospitals' burden of segregating and documenting capital assets in preparation for these audits.

Other implementation concerns KHA believes must be addressed if the system is implemented include timeliness of payments to hospitals during the transition, as well as interim payments until all cost data are available; creation of a timely appeals process and changes needed to the Medicare cost reporting form.

In light of current law requiring the change, KHA, in its comment letter to Health Care Financing Administration Administrator Gail Wilensky, recommended a number of changes and modifications in order to minimize potential harm to hospitals. Some of the most important recommendations for modifications include: inclusion of a permanent exceptions process responsive to a hospital's circumstances; recognition of the variances of individual hospitals' capital cycles; and provisions of a more liberal definition of old capital, particularly one that includes leases, rentals, home office costs, and other capital costs, and one that takes into account obligated funds which have not been included in the base year calculations.

KHA further disagrees with HCFA's assertion that the current pass-through methodology for Medicare payment for capital costs provides inappropriate incentives for hospitals and that a new payment methodology is needed to avoid those incentives. In other words, the regulations appear to be a solution looking for a problem which does not exist. No empirical data exist to support the contention that hospitals have been making inappropriate capital acquisition decisions. On the contrary, industry data show that the proportion of resources the industry is devoting to capital has remained relatively stable in recent years. Information from the Prospective Payment Assessment Commission, the American Hospital Association, and the Healthcare Financial Management Association shows that hospitals' proportion of capital to operating expenses, as measured by median values of the their capital expense ratios, has remained less than 10 percent since 1985. The loss of the cost-based system has the potential to seriously alter this balance and eventually affect the cost or even availability of financial capital.

It should be noted that few rural hospitals have taken issue with the proposed rules because, on the surface at least, it would appear that most will come out as "winners" under the system. KHA agrees that in the short run, most rural hospi-

tals will probably benefit under the system. This is due primarily to the economic conditions of rural hospitals, most of which are at the end of their capital cycle. For the most part rural hospitals have not been able to replace their physical plant and major equipment and therefore have very low depreciation, debt service, interest and other capital-related costs.

To illustrate the tremendous inequities that will result from the proposed system I will describe a real situation which identifies the problems that are inherent in the system. The median capital cost per discharge for 11 reporting Kansas rural hospitals with fewer than 100 beds in a national data bank was $293.31 per discharge in 1989. On the surface, a payment rate of nearly $412.00 looks quite attractive, but only if all conditions remain constant.

The actual capital costs per discharge of a small hospital in Kansas that was recently replaced is over $900 per discharge. The occupancy of this hospital approximates the occupancy ratio for rural hospitals published in the Federal Register. This hospital will be protected during the transition period under the "hold harmless" provisions of the regulations because they were fortunate enough to replace their facility prior to their base year. However, the other 100 or so rural hospitals in Kansas with old facilities would not be so fortunate.

The 11 hospitals in the survey previously mentioned and many others who are in similar situations, all of which are appropriate for this illustration, would receive only $630 per discharge including exception payments. This equates to only slightly over two-thirds of their actual cost if they were to replace their facilities under the proposed system at the same cost as the hospital that was recently replaced. It should be noted that the $630 is an average and that payment in the earlier years would be even lower. These losses will be even greater after the transition period is completed as they would no longer be protected under the transition rules. Alter 10 years, these hospitals would be reimbursed an estimated 50 percent of their capital costs, depending on update factors and future capital expenditures.

This illustration points out five key inequities of the proposed system:

1. Only those hospitals whose capital timing is right receive protection under the system to prevent major financial short falls for the first 10 years. The majority of hospitals who will need to update their facilities and equipment after their base year will be severely disadvantaged to the point where they will unlikely be able to do so.

2. Rural hospitals who do not have to update their facilities will, in the short term, be "winners" in the system. Those who are required to update their facilities will likely be "losers" and their losses will be significant. The determining factor of whether a hospital is a winner or loser in the game of averages has little to do with operating efficiencies but rather with timing and the regulations do not permit hospitals to plan the timing.

3. The exception provisions are not adequate. While the system attempts to provide protection to hospitals during the 10-year transition period by providing for exception provisions, the facts presented reflect that the exception provisions are inadequate. The average rural hospital that replaces its facility will absorb a loss of over $300 per discharge.

4. Of the $630 per discharge that would be received by a hospital who update their facility after the base year, 44 percent would be an exception payment which would not be paid until the cost report was settled. This magnitude of cash flow lag could not be absorbed by a small rural hospital that is currently struggling for survival.

5. The capital cost per discharge of the recently constructed rural hospital clearly reflects that capital costs have no relationship to the hospital's wage index which is used as a basis for calculating "local Cost Variation" in the regulations. Capital cost per discharge also does not relate to relative input prices (cost per unit of material and labor). The previously mentioned rural hospital which was recently replaced is a modest facility financed by the Farmers Home Administration at an annual interest rate of less than 6.0 percent. Of its total capital cost per discharge of approximately $900, 33 percent is interest and 27 percent is depreciation on movable equipment. Neither of these factors, which total 60 percent of its capital costs, relate to national pricing structures and have no relationship to the Kansas rural wage index of .7457. In our opinion there is no significant relationship between the capital cost per discharge and the area wage index. Rather the difference in capital cost per discharge between facilities depends on the types of services rendered, the number of discharges, and the point that the hospital is in its capital cycle.

KEY RECOMMENDATIONS

Expansion of the Exceptions Process

To offer hospitals protection from the onerous provisions of these regulations a permanent payment floor for all hospitals should be a part of the rules. Additionally, special provisions for Sole Community Hospitals, Rural Referral Centers, Rural Primary Care Hospitals and Medicare Dependent Hospitals should be offered the same protection in the new regulations as they currently receive under the cost based system.

Hold-Harmless for Existing Capital

To provide a true hold-harmless provision and to facilitate more equitable payments across hospitals the definition of "old" capital should be consistent with the current Medicare definition of capital-related costs. This includes leases, taxes, insurance, home-office capital costs, and other capital-related costs that are now recognized.

Payment Updates

HCFA's method for projecting capital growth rates from 1988 to 1992 underestimates growth, therefore, the base Federal is set artificially too low and the method for updating the rates beyond 1995 is not explicit. Payments should be updated annually to take into account the actual increase in the cost of capital to hospitals based on the most recent cost report data.

Additional Adjustments

Three additional adjustments should be made to account for variations in costs among hospitals.

1. Geographic Adjustment:

The use of the area wage index to adjust for geographic variation is inadequate and should only be used until a more representative index can be developed. Variations across geographic areas in cost of equipment, building material, other nonlabor costs, and local building requirements must be accounted for more appropriately. Hospital construction wage rates should also be included in a local variation adjuster.

2. Capital Cycle Timing Adjustment:

The proposal does not adjust for timing and financing of capital acquisitions. An adjustment for the timing of capital investments is essential to reduce the disruptive effects of a change in capital policy.

3. Reliance on Debt Adjustment:

A permanent adjustment should be developed and tested to reflect a hospital's reliance on debt. A hospital's level and cost of debt is a significant factor that should be reflected in a adjustment to the base payment rate.

CONCLUSION

Despite the tremendous competitive, financial and environmental pressures on both urban and rural hospitals significant progress is being made towards delivering quality and cost-effective health care. Cooperative efforts in Kansas have resulted in six hospitals merging and four others converting to other levels of care and service. The development of regional rural health networks, fueled by the EACH/RPCH concept demonstrates the commitment hospitals have to ensuring access to quality health care for Medicare beneficiaries. Communities are participating with one another in the type of dialogue necessary to continue this progress. Testimony by ProPAC confirms the fact that over the past several years capital spending has slowed and the vast majority of capital expenditures undertaken by hospitals today are both prudent and necessary to meet future health care needs. The implementation of these regulations, without change, could seriously jeopardize these efforts.

Notwithstanding the requirements of the current law, KHA continues to believe that any policy change concerning Medicare payment for capital costs is unnecessary and could endanger Kansas hospitals, many of which are already in precarious financial conditions. However, unless the law is actually changed, Congress should make certain that HCFA's proposed payment system is modified as suggested in order to prevent as much harm to hospitals as possible.

COMMUNICATIONS

STATEMENT OF THE ASSOCIATION OF FREESTANDING RADIATION ONCOLOGY CENTERS

The Association of Freestanding Radiation Oncology Centers ("AFROC") is an association of over 150 freestanding oncology centers located throughout the country. Freestanding radiation oncology centers are health care facilities organized and operated to provide high-quality, cost-efficient radiation oncology services to patients in their communities outside of the hospital setting. It is estimated that there are approximately 300-350 freestanding radiation oncology centers located throughout the country. Freestanding radiation oncology centers are heavily dependent on Medicare reimbursement, since approximately 55% of patients treated by such centers are covered under the Medicare program.

The provision of radiation oncology services outside the hospital setting requires significant capital investment, and the ongoing operation of such centers entails high expenditures for specialized staff, equipment, maintenance, and other "facility" costs. In effect, such costs are comparable to the "facility" costs incurred by hospital outpatient departments that provide the same services.

Such "facility" costs are not reimbursed separately by the Medicare program; rather these "facility" costs are currently reimbursed as the "technical" component of radiation oncologists' fees, under the radiology fee schedule. Unfortunately, the radiology fee schedule does not take into account extraordinary facility costs involved in providing radiation oncology services in freestanding settings. The relative values for radiation oncology "technical" services were derived by the American College of Radiology using a methodology that did not take these cost into account. For this reason, the reimbursement allowed under the radiology fee schedule does not cover the actual costs of providing radiation oncology technical services, and the cost of providing these services must be cross-subsidized using revenues obtained from other third party payers.

Moreover, after the implementation of the radiation fee schedule in April 1989, Congress enacted legislation which reduced reimbursement for radiology services (including the technical component of radiation oncology services) by approximately 30% in 1989, 4% in 1990, and approximately 9.5% in 1991.

As a result of these factors. a study conducted by AFROC during the period from December 1990 through January 1991 established that reimbursement would have to be increased by at least 47% to ensure that technical relative values are sufficient to cover actual costs. More specifically, from December 1990 through January 1991, the Association of Freestanding Radiation Oncology Centers ("AFROC") sponsored a survey of the technical costs incurred by freestanding radiation oncology centers. No member of the Board of Directors nor any other member of AFROC was provided access to any of the individual data collected.

Approximately 80 facilities responded to the AFROC survey, representing approximately 23–27% of all freestanding facilities in the country. The survey respondents were divided into categories, depending upon the number and type of treatment units available at the facility, and, for each of these categories of facilities, annual technical costs were computed. The average number of treatments provided by each type of facility was also computed by annualizing survey data for the three-month period from July to September 1990.

After obtaining the average number of patients for each type of facility and the average cost for each type of facility, a "break-even conversion factor" was computed by dividing the total costs by the total current relative values. This conversion factor represents the conversion factor that would be necessary in order for each type of facility to "break-even" given *current* relative values. The results are as follows:

	Single unit center beam energy (MV)				Two unit centers
	0–5	6–10	11–19	20+	
No. of centers	20	39	2	1	17
Tech cost($K/yr)	497	800	916	1,027	1,490
Treatments/yr	3,332	5,584	5,788	5,548	12,780
Tech RVUs/yr	27,257	46,241	47,872	45,898	105,733
Tech cost ($)/RVU	18.09	17.31	19.13	22.39	14.09

Thus, the study demonstrated that, regardless of the category of the facility, *current* reimbursement levels are too low to cover actual costs. In fact, using this data, AFROC has calculated that an increase of approximately 47% in the current relative values for these services would be necessary in order for freestanding radiation oncology centers to "break-even." These results were confirmed by an independent study conducted by Pro-Med, a cancer center management and consulting firm.

The Health Care Financing Administration ("HCFA") is now in the process of integrating the current radiology fee schedule, however, (including the current reimbursement for freestanding radiation oncology centers) into the resource-based relative value scale ("RVRVS"). In its recently proposed Notice of Proposed Rulemaking ("NPR"), HCFA proposed a further 10–15% reduction in reimbursement for radiation oncology technical services. This proposal is entirely inconsistent with a "resource-based" approach to reimbursement, since the current reimbursement levels were not based upon study of the resources involved in the provision of radiation oncology services in freestanding settings. In addition, this proposal is inconsistent with the approach recommended by the Physician Payment Review Commission ("PPRC"), which has recommended that reimbursement be based on a study of the actual resources used.

For these reasons, AFROC respectfully requests that the Committee urge HCFA to adopt reimbursement levels for radiation oncology services that accurately reflect the resources used and support the introduction of legislation that would require HCFA to take into account the resources used in the provision of these services in implementing RBRVS, if HCFA fails to take these extraordinary costs into account in finalizing the fee schedule.

If you have any questions or need any further information regarding AFROC's position on this issue, please contact AFROC's legal counsel, Diane Millman at (202) 778–8021.

Statement of the Greater New York Hospital Association

Greater New York Hospital Association (GNYHA), which represents 130 nonprofit voluntary and public hospitals and nursing homes in the metropolitan New York City region, appreciates this opportunity to testify before the Senate Finance Committee on the critical issue of capital financing under the Medicare program. GNYHA's statement today will provide our analysis and findings with respect to HCFA's proposal for converting Medicare capital reimbursement from a cost-based methodology to a case-based prospective payment methodology. It will also provide a set of recommended modifications to the proposed payment rule that would signficantly improve its ability to meet the capital financing needs of our member institutions and similarly situated hospitals across the United States. Finally, attached to the statement is a copy of GNYHA's formal comments to HCFA on the proposed rule, which includes, in detail, our analysis of the fiscal and health care impact of the proposed rule, along with an explanation of our analytical process and recommended modifications.

The policy direction of capital reimbursement is of vital importance to the voluntary hospitals in the New York City region, many of which are in the midst of or are about to undertake major reconstruction projects. Our goal is simple: to ensure the viability of institutions that are the primary or sole provider of health care services in communities with significant elderly and poor populations.

General assessment of proposed capital payment rule

HCFA's proposed capital payment rule would provide an average capital payment per discharge in an effort to encourage more prudent capital planning and expendi-

tures. The theoretical underpinning of the rule is that hospitals will accumulate retained earnings during years in which capital payments exceed capital costs, and apply those earnings toward future capital formation. GNYHA believes that this theory is invalid because it ignores two critical factors: (1) the capital cycle; and (2) the severe financial pressure under which our hospitals operate.

Because the proposed rule in its current form fails to accommodate these factors, it would cause considerable hardship to many of the voluntary hospitals in the New York City region, including default on contractual spending obligations and/or the postponement of vital capital investment. These hardships would occur in the face of overwhelming community need for the health care services provided by our membership, as indicated by an average inpatient utilization rate of almost 90% and an average disproportionate share percentage of over 30%.

The Capital Cycle

Any large, complex facility requires continual maintenance and repair, as well as periodic rebuilding according to the age of plant. During the rebuilding phase of the capital cycle, costs are generally much higher than in other periods because:

- Physical plants often last much longer than the term of the mortgages assumed to construct them. Hence, during the years after a mortgage has been repaid but before the next renovation is begun, hospitals often have years without significant interest and depreciation costs.
- Even during periods of mortgage repayment, capital-related costs are frequently higher in the early years than in the later years due to declining interest payments.

A combination of factors has put many New York voluntary hospitals in a position of undertaking major modernization programs in the 1990s. First, New York's hospitals are much older than those in other parts of the country. Second, during the early 1980s, New York State imposed a moratorium on major rebuilding projects. This moratorium, combined with the depressed economy of the mid- to late-1970s, caused many institutions to delay until now the badly needed renovation of facilities that are several decades old.

Our analysis shows that at least 19 GNYHA member voluntary hospitals are in the construction or planning stages of major modernization projects that will be completed after 1989. This cut-off date is significant because the proposed capital payment rule provides cost-based hold harmless payments for depreciation and interest pertaining to assets acquired as of the base year, which is 1989 for most hospitals in New York State. If these hospitals proceeded on schedule with their projects, each would receive cumulative capital payments over the next 15 years representing less than 85% of their capital costs, with some receiving cumulative payments as low as 55%–60% of costs.

As of 1989, several of the hospitals already had construction underway, including North General Hospital, The Presbyterian Hospital in the City of New York (Columbia-Presbyterian) and St. Luke's-Roosevelt Hospital Center. If the Medicare capital payment rule were promulgated as proposed, these institutions would be at great risk of defaulting on mortgage and other contractually obligated payments. By the time the capital payment rule was proposed, other hospitals, at a somewhat earlier stage in their project development, had spent millions on engineering, architectural, planning, and other costs. These hospitals, including Montefiore Medical Center and The Society of The New York Hospital, risk not only default on payment obligations, but also the interruption and delay of vitally needed capital improvements. Finally, hospitals with less advanced modernizations scheduled to commence during the 10-year transition period, risk the indefinite postponement of their projects, to the detriment of the health care of their communities. These projects have not yet received significant investments, but they have received Board review and are deemed to be necessary at this time.

In order to serve the health care needs of their communities, hospitals must undertake capital improvements when they are required based upon the capital cycle of their facilities. The timing of such improvements cannot be forced to conform to an arbitrary reimbursement schedule without risking adverse financial and health effects. The rebuilding projects underway or planned by the GNYHA member hospitals are urgently needed, as many of the antiquated facilities do not meet current safety, electrical, plumbing and other code requirements, nor can they accommodate state of the art medical equipment.

Financial Pressure on New York Area Voluntary Hospitals

A preliminary analysis of the 1990 profit and loss picture for New York's voluntary hospitals by the Hospital Association of New York State (HANYS) shows that over 85% of the hospitals in the New York City region have negative operating

margins and close to 75% have negative total, or bottom-line, margins. This extreme financial pressure makes it unlikely that GNYHA members would ever be in a position to accumulate retained earnings for future capital formation: they are struggling as it is to meet their current obligations.

PROPOSED CAPITAL PAYMENT RULE IN CONTEXT OF NEW YORK STATE

Congress directed HCFA to develop a prospective payment methodology for Medicare inpatient capital-related costs in order to curb unrestrained and sometimes inappropriate spending that seemed to be motivated by the cost-based payment methodology. However, this rationale for moving to a prospective payment system for capital is not applicable to hospitals in New York State because they are already greatly constrained in their capital decision-making due to a highly restrictive certificate of need (CON) approval process. This process—with all its attendant flaws, including compliance costs and project delays—does ensure the necessity of all major capital investments. Evidence of the lack of overbuilding is the State's high aggregate occupancy rate.

FINDINGS OF THE GNYHA FISCAL IMPACT ANALYSIS

Because we believe that the major reconstruction projects underway or planned by our membership should proceed as scheduled to appropriately respond to the health care needs of the Greater New York community, we conducted our fiscal impact analysis of the effects of the proposed regulation assuming a level of future Medicare inpatient capital-related costs that reflected these projects. Based upon these and other assumptions provided by the hospitals, we conducted a 15-year analysis to project the payments generated by the proposed rule both during and beyond the 10-year transition period. Several key findings emerged from our analysis, as follows:

- Compared with cost-based reimbursement discounted to 85%, "high cost" hospitals—i.e. those in the building phase of their capital cycles—shift $650 million to "low cost" hospitals that do not require these revenues;
- The $650 million loss to high cost hospitals doubles the loss due to the 15% discount on cost-based reimbursement, bringing total losses to $1.3 billion;
- For individual GNYHA hospitals, 57% receive cumulative 15-year payments of less than 100%, 43% receive cumulative payments of less than 85%, and 27% receive cumulative payments of less than 75%;
- Even hospitals with cumulative 15-year payments in excess of 85% of costs experience severe cash flow pressures in years of higher-than-average capital formation, since payments are not computed in relation to costs; and
- While over a cumulative 15-year period, member hospitals as a group receive roughly the same level of capital payments as under cost-based reimbursement discounted to 85%, the aggregate level of reimbursement on an annual basis varies widely during the 15 years from over 90% to below 80%.

These findings demonstrate that the proposed Medicare capital payment rule would generate an insufficient level of reimbursement for many of our member hospitals, both on an annual and a cumulative long term basis.

RECOMMENDED MODIFICATIONS TO THE PROPOSED CAPITAL PAYMENT RULE

Based upon these findings, GNYHA proposes several modifications to the proposed capital payment rule to ensure an adequate level of capital formation for our member institutions and their communities, as follows:

- Changes to Provisions in the Current Proposal

Hold Harmless Provision

—Incorporate total allowable Medicare inpatient capital-related costs in the definition of old capital, including leases, rentals, taxes and insurance as well as depreciation and interest;
—Extend the transition period from 10 years to 15 years; and
—Remove the cap on the new capital ratio, which limits the proportion of the Federal rate that hold harmless hospitals can receive for new capital to the national average ratio of new capital to total capital.

General

—Change the base year from 1989 to 1990; and
—If hold harmless and/or exceptions payments exceed the budget neutral spending level, then spread the reduction over total Medicare operating and capital

payments rather than reducing hold harmless and/or exceptions payments as HCFA proposes, which would hurt the most vulnerable hospitals.
—Special Exceptions Provision (which helps to cover shortfalls in capital payments for high DSA hospitals)
—Do not reduce special exceptions payments where total Medicare payments exceed Medicare costs due to Congressionally mandated add-ons such as DSA, IME and GME;
—Lower the DSA eligibility threshold for special exceptions capital payments from 30% to a level closer to 20.2%, the threshold for high DSA hospitals under PPS; and
—Provide the same level of deficit reimbursement for all hospitals eligible for special exceptions payments rather than the proposed sliding scale, which arbitrarily categorizes hospitals according to their growth in capital spending between 1989 and 1992.

Federal Capital Rate Adjustments

—Replace the proposed geographic adjustment factor with a construction cost index;
—Use the PPS DSA formula in the capital rate; and
—Provide an IME adjustment to the capital rate.

• **New Provisions Pertaining to Hospitals with Obligated Capital Expenditures as well as Hospitals with Planned Expenditures**

—Create a hold harmless or exceptions provision to protect hospitals that have contractually obligated capital expenditures and have invested $1 million or 1% of inpatient operating costs by the publication date of the final rule; and
—Create a permanent hold harmless or exceptions provision for hospitals with planned, but not yet obligated, capital projects, using certain criteria to establish eligibility, as follows:

- High occupancy rate, such as 80%;
- High DSA percentage, such as 20.2%;
- CON approval or State or Federal mandate;
- High asset turnover rate, such as 1.00; and
- High bed turnover rate, such as 50.00 discharges per bed.

We believe that incorporation of these recommendations into the final capital payment rule would ensure the feasibility of the needed building programs of our member hospitals, while preserving the integrity of the prospective system. We appreciate the dialogue that the Congress and HCFA have maintained with us pertaining to the Medicare capital payment methodology and look forward to continuing these discussions. Thank you very much for this opportunity to present our views.

Statement of the Healthcare Financial Management Association

INTRODUCTION

HFMA disagrees with HCFA's assertion that the current pass-through methodology for Medicare payment for capital costs fosters perverse incentives for hospitals and that a new payment methodology is needed to avoid those incentives. No empirical data exist to support the contention that hospitals have been making inappropriate capital acquisition decisions. On the contrary, data show that the proportion of resources the industry is devoting to capital has remained relatively stable in recent years. HFMA's Financial Analysis Service (FAS) shows that hospitals' proportion of capital to operating expenses, as measured by median values of their capital expense ratios, has remained less than 10 percent since 1985. FAS is a database of audited hospital financial statements. The American Hospital Association and the Prospective Payment Assessment Commission corroborate HFMA's findings.

The loss of the cost-based payment method may negatively affect the cost or even the availability of financial capital. The current payment method provides a predictable and stable cash flow to hospitals for their capital commitments.

However, HFMA also realizes that current law requires Medicare capital costs for PBS hospitals be paid prospectively effective with cost reporting periods beginning on or after October 1, 1991. To reduce potential harm to hospitals, HFMA recommends that HCFA modify its proposed rule in several important respects.

TECHNICAL CONCERNS

DRG case weights and outliers are unrelated to capital costs.—Rather than a true PPS system for capital, HCFA has proposed a hybrid payment system that uses components of the PPS operating system that are not demonstrably capital-related, notably the DRGs themselves and the outlier payment system. The DRG weights do not have a direct correlation to capital costs, especially at higher case-mix levels. Similarly, the last days of a patient stay, which allow a patient to qualify for day outlier payments, may be the least capital-intensive portion of a patient's stay. These "imported" payment components inevitably compromise payment equity.

Lack of a long-range view.—HCFA's proposed transition is not long enough. Financing instruments for large-scale building projects are typically for terms as long as 30 years. Projects being planned now will not be completed until near the midpoint of the transition. Lenders must think in long-range terms when judging hospitals' creditworthiness and are likely to charge higher interest rates to compensate for reduced assurances of repayment over the life of a debt.

In addition, the proposed exceptions process makes no provision for post-transition help for hospitals needing additional assistance. It is unlikely that the circumstances warranting an exception in the early years of the transition will cease to exist in post-transition years. Hospitals that must undertake renovations or purchase equipment to meet regulatory requirements, such as life safety code requirements, or facilities that must meet the special costs of construction in earthquake-prone regions, are strong candidates for special consideration. HFMA supports a permanent exceptions process that will provide flexibility to hospitals as they deal with the uncertainty of the post-transition period.

Rigid payment tracks.—HCFA is proposing a one-direction, "lock-step" transition that gives hospitals no options among payment methods. Hospitals that are "high cost"—by HCFA's narrow definition—at the outset of the transition are locked into the discounted, partially cost-based, hold harmless payment method. Models developed by HCFA show that, after several years, some of these hospitals would receive higher payments under the other, fully prospective method. Similarly, hold harmless hospitals are locked permanently into the Federal rate once their old capital costs fall below that rate, even though a blended rate might be higher. This automatic system further creates inequitable payment differentials among similar hospitals that may be at different points in their payment cycles.

Failure to acknowledge a capital cycle.—The proposed regulations do not accommodate the existence of hospitals' capital spending cycles but, rather, lock in fixed hospital-specific rates for the duration of the transition a hospital's situation at a possibly atypical point in time. As a result, hospitals that were at the beginning of a building program in FY90 will be particularly disadvantaged by these regulations, simply because of the timing of their cycle.

Data from HFMA's FAS database indicate a cyclical pattern of capital spending. In 1988, an analysis of 3,356 hospitals revealed an inverse correlation of the median values of the capital expense ratio with the average age of plant. This relationship demonstrates that hospitals with older plants and equipment tend to be at the low end of this capital cycle, while hospitals with newer plants and equipment tend to be at the high end of the cycle. HFMA members' comments in response to the proposed regulation indicate that, just before a major building project or renovation, individual hospitals deliberately and substantially slow the process of acquiring major equipment, in anticipation of the move or renovation. They thus incur lower capital costs in this preparatory time period, followed by sharp cost increases once the project comes "on line." Hospitals that can demonstrate that their base year is atypical should have the opportunity to petition for an alternative base year.

Choice of wage index as geographic adjuster.—Since the inception of PPS, the area wage index has been plagued by methodological problems. Congress' establishment of the Medicare Geographic Classification Review Board (MGCRB) was based on concerns about the validity of the index. Given these problems, a refined construction cost index for use as a capital geographic adjuster should be adopted. The Center for Health Economics Research, in a 1989 report to HCFA, suggested that an input price index could be computed for HCFA's use, and that it would be preferable to the construction cost index currently available. A new input price index would have the advantage of being directly related to capital costs.

If a construction index is not adopted, HFMA assumes that hospitals reclassified by the MGCRB would receive the geographic adjustment of their new wage area. HCFA should clarify this point in the final rule.

Inadequate exceptions policy.—As already noted, HFMA urges establishment of a permanent exceptions process after the transition. Even within the framework of

the transition, however, the proposed exceptions policy is entirely inadequate. The thresholds are high, so that only hospitals whose capital costs far exceed their payments can qualify. In addition, HCFA has said that it may raise the thresholds year by year to meet budgetary targets. This action would make the entire exception provision undependable. A true and permanent exceptions policy that weighs individual hospital's situations must be established.

Obligated capital inadequately defined and poorly protected.—For hold harmless payments, HCFA defines old capital as allowable Medicare inpatient depreciation and interest expenses for capital assets in use for patient care and appearing on the hospital's latest cost report ending on or before the close of Federal FY90. Capital not meeting this criterion is classified as new capital. The proposed "special payment" method allows hospitals that have higher-than-average costs in 1992 to choose the payment method yielding the higher payment.

Despite its intent, this special method does little to help these hospitals. It does not provide for treatment of obligated capital as old capital. Moreover, a hospital's opportunity to qualify is limited to 1992, a constraint that is unwarranted because projects obligated in FY90 often will not be on line until 1993 or later. Many hospitals will be seriously harmed if these assets are not treated as old capital.

Obligated capital must be better protected. Several options are available. Most important, HCFA must adopt a more liberal definition of old capital to include obligated capital.

HFMA believes that a formal resolution empowering management to proceed with a project and execute contracts, adopted by a hospital's governing board and recorded in the minutes, should be sufficient to prove that a firm obligation does indeed exist. These resolutions are based on detailed information about the project's scope, cost, and proposed financing, and they usually indicate that certain representations and commitments have been made to various third parties to proceed with the project. If the hospital can document that its board's resolution was based on such information, HCFA should accept the resolution as adequate evidence of a firm commitment to qualify the asset as old capital.

It should be noted that HCFA has in the past accepted a hospital board resolution as evidence of the institution's official commitment to a course of action. In the *Provider Reimbursement Manual,* HCFA accepted such a resolution as proof that an advance refunding of debt had been initiated.

Other criteria that may be used to verify that a hospital has made a serious commitment to undertake a project, in order of their usual occurrence, are: engagement of an underwriter to secure financing; application to a debt issuing authority; official action by a debt issuing authority indicating a clear intention to finance a project; expenditure of funds in proportion to the expected total size of the project; for example, for facility planning, for engineering studies, or for architectural work; and evidence that construction was under way.

Leases and rentals excluded from old capital.—HCFA's proposal to exclude leases and rentals from its definition of old capital under the hold harmless payment method inappropriately penalizes hospitals that selected leases or rental agreements to finance capital acquisitions. Leasing is a legitimate approach to financing and should not be a basis for unfavorable payment rules. Hospitals choose to lease for a variety of sound economic and financial reasons unrelated to Medicare payment. Reasons include a desire to avoid the risk and expense of owning equipment that may soon become obsolete and cash flow considerations. In some circumstances, a hospital must rely on leasing because debt financing is unavailable. These options must continue to be available.

The proposed regulation would distinguish old capital from new based primarily on the asset itself. We believe this basis is appropriate, because the acquisition of an asset is distinct from the choice of financing mechanism. However, HCFA's proposal to exclude leases and rentals from its definition of old capital shifts the basis of the definition from the asset to the financing mechanism, thereby destroying the consistency of the distinction between old and new capital.

Furthermore, a lease often is merely an arrangement whereby a hospital pays for an asset over time. These arrangements should not be penalized by Medicare payment rules.

The instrument that secures industrial revenue bonds issued by many jurisdictions in order to finance hospital building projects takes the legal form of a lease. These leases are not payment arrangements but, rather, legal agreements between a bond issuing authority and a hospital. We do not believe it is HCFA's intent to exclude from the definition of old capital projects financed by industrial revenue bonds under this type of arrangement but that should be clarified in the final rule.

HFMA also is concerned that HCFA's proposal to define old capital differently from new capital may undermine the consistency of the current Medicare definition of Medicare capital-related costs. If leases and rentals are excluded from old capital, hospitals will, as a practical matter, have to cope with multiple definitions of capital.

We understand that several considerations led HCFA to exclude leases and rentals from old capital:

- That the sheer variety of leasing arrangements makes it difficult to predict Medicare's potential outlays for the purpose of estimating budget neutrality;
- That equipment can be replaced under a continuing lease, so that new capital might masquerade as old; and
- That, while purchased assets are depreciated over their useful life according to Medicare's straight line depreciation method so that Medicare's liability is clearly defined, allowable lease and rental costs are not as easily controlled.

Although we understand these problems, we do not see them as insoluble. Regarding the first concern, HCFA's inability to calculate budget neutrality precisely is not a good reason to adopt a flawed policy. In other areas of Medicare program administration, for example, when updating rates for inflation HCFA is satisfied with estimates, although actual outlays may be different.

Regarding the concern that new capital may masquerade as old, HCFA's definition of old capital, as previously noted, properly focuses on the asset itself, not the financing instrument. It is possible to document a capital asset's identity by evidence verifiable by an intermediary, such as titles, deeds, or model numbers. The burden would be on each hospital to provide appropriate documentation to the fiscal intermediary.

Regarding HCFA's third concern, Medicare-allowable costs related to lease or rental payments are already clearly defined and controllable by mechanisms in regulation and in instructions to intermediaries. FIs can limit allowable lease costs by tests of reasonableness and specific regulatory limits eliminating the necessity for new limits.

Other assets excluded from old capital.—As with leases, HCFA has given no rationale for excluding from the definition of old capital such costs as insurance, taxes, license fees, royalty fees, home office capital-related costs, and related organizations' capital-related costs of depreciable assets not located on the hospital's premises. All of these costs should be included in the definition, as should bond issue expenses related to old capital assets, because they are directly related to the asset's acquisition and use. With regard to assets on the premises of related organizations and shared assets, such as major diagnostic equipment purchased by a hospital jointly with related or unrelated entities, HCFA's proposal to exclude them from old capital discourages sharing and is contrary to HCFA's announced cost containment objectives. It is feasible to distinguish old capital from new capital regardless of site, and insurance and tax costs can be related to old and new assets and assigned to capital and administrative cost centers based on principles already available.

Revaluation of assets and recapture of depreciation.—When a hospital sells an asset, HCFA proposes to recapture its share of any excess of the sale price over the asset's net book value. It has further explained that the adjustment will be made only with respect to old capital for which a hold harmless payment is made. HCFA has not described what it will do when a sale results in a loss, but HCFA staff members have indicated that the agency will recognize the loss as additional depreciation and pay its share over the life of the asset. HCFA should affirm this intent in its final rule. This adjustment should not be limited to assets paid under hold harmless provisions, because the hospital should recoup all cost payments relevant to the years paid on a cost basis. In addition, any allowable costs related to a sale should be reflected in the hospital's hospital-specific rate.

That these adjustments will be made throughout the transition for assets sold during the transition should be clarified. In other words, if an asset is sold in 1999, a hospital's transition rates and payments will be adjusted retroactively.

Treatment of interest expenses.—Interest expense is an integral part of capital costs. HCFA has indicated that it intends to apply current Medicare rules regarding the distinction between capital-related and operating interest costs to establish allowable capital interest expense and the appropriate allocation of interest costs between old and new capital for the purposes of payment under the hold harmless method. HFMA believes that several key questions remain unanswered. In particular, the government's policy on the following needs to be clarified:

- The underlying basis for the allocation of interest expense to old and new capital.

- Refinancings and consolidations that result in lower interest costs.
- Advance refunding of debt, particularly with regard to losses on defeasance.
- Funded depreciation.

Allocation of interest expense to old and new capital.—HFMA believes that throughout the transition HCFA must continue to pay its full share of the interest costs attributable to assets paid under the hold harmless method. The payment system's focus should remain consistent: the asset, not the financing instrument, is the basis for the distinction between old and new capital. The costs should be allocated to old and new capital based on the proportion of the assets that qualify as old or new capital.

Allocation of interest expenses to old and new capital; debt refinancing.—The section of the proposed regulation dealing with debt refinancing is incomplete and confusing. The proposed allocation of interest expense to old and new capital under the hold harmless payment method is entwined in this confused discussion of refinancing. In the proposed regulation, HCFA assumes that the only way old and new capital could be co-mingled in a single debt instrument would be through a refinancing of debt. For this reason, it is assumed that the point at which the debt is refinanced is identical with the cutoff point for old capital. This assumption leads to the substitution of the financing instrument for the asset in distinguishing between old and new capital. However, it is possible that several assets financed by a single debt instrument came "on line" at different points in time and that only some of those assets qualify as old capital. One example of this situation would be a phased-in project. Another example would be a situation where several existing debts relating to old and new capital had been consolidated in the past. Any payment system needs to explain the allocation of interest expense in the more general case, in which old capital and new capital are co-mingled within a single debt instrument, before proceeding to the more complicated situation of debt refinancing.

When a debt refinancing or consolidation results in increased interest expense, HCFA proposes to limit the amount of interest expense related to old capital to the amount that would have been recognized prior to the refinancing or consolidation. This is appropriate.

The proposed regulation does not contain HCFA's policy on refinancings that result in decreased interest expense. Hospitals most often refinance loans to take advantage of lower rates. HCFA should take the opportunity to encourage refinancings that result in reduced cost.

Advance refunding of debt.—Advance refunding is a refinancing technique which enables a hospital to replace existing debt before its scheduled maturity. A hospital may consider advance refunding for a variety of reasons: to get a lower interest rate, to improve cash flow, to remove restrictive covenants, or to increase borrowing capacity. HCFA has previously indicated that revenues and expenses associated with advance refundings should be treated in accordance with current manual instructions.

In its final rule, HCFA should confirm that it will pay its share of all legitimate costs associated with a refunding, allocating them to old and new capital according to the proportions of the assets involved. Certain costs, such as debt cancellation costs on the refunded debt, interest expenses on the refunded debt, and any losses on defeasance, are clearly associated with the old debt, and should be allocated to old and new capital according to the proportion of old and new capital assets financed through the old debt. These arrangements should be allowed throughout the transition period. Other costs, such as debt issue costs on the refunding debt, and interest expenses on the refunding debt, would be considered new capital.

Funded depreciation.—HCFA has argued that a prospective payment method for capital, because it pays for an asset's use in patient care and not for the asset itself when purchased, will force hospitals to save for future capital expenditures. However, the proposed system provides no encouragement or assistance to hospitals in building equity for future capital needs. At a minimum, HCFA should make it clear that offsets of interest income will not be taken if an account is set up for future investment in capital and that the interest expenses of new borrowing will not be disallowed because a hospital has invested depreciation funds. The same protection should be guaranteed for income from both restricted and unrestricted donations, because hospitals will need to undertake more fundraising to finance capital needs in the future if HCFA's proposal is implemented. These guarantees will benefit only hold harmless hospitals, since as soon as the rule goes into effect, hospitals paid a fully prospective rate will have no payment incentive to have separate funds for future capital since their capital-related interest expenses will no longer be paid on a pass-through basis. HCFA should create a direct incentive to encourage capital saving.

CONCERNS REGARDING IMPLEMENTATION

Implementation of the capital PPS payment method will be costly for HCFA and burdensome for hospitals, because fiscal intermediaries must undertake hospital-specific rate calculations at the outset and conduct detailed audits of capital costs each year. Hospitals will have the burden of segregating and documenting capital assets in preparation for these audits.

Because of the complexity of the system, an intricate process of payment adjustments will be necessary. HCFA will need to provide its intermediaries with detailed instructions and hold them to fair and consistent requirements. HFMA has the following specific concerns:

Timeliness of payment.—Timely capital payments are crucial to hospitals, particularly during the first year of the transition from cost-based to prospective payment. Hospitals now receive a regular capital payment and must continue to receive one without interruption. HCFA has already acknowledged that this will be particularly difficult for hold harmless hospitals and has properly provided for interim payments until complete FY90 cost data are available.

To determine these payments, however, HCFA says its intermediaries need information from hospitals on old capital. This information must be provided by the hospital 120 days before the date the hospital would begin its first cost reporting period on or after October 1, 1991, in order to calculate the interim rate 30 days in advance of that date. These deadlines are already unrealistic, given the delays in publishing the proposed rule. HCFA must either give its intermediaries additional resources to process the information quickly, provide an interim payment based on past cost payments, or delay the rule's implementation.

Appeals.—We are pleased that HCFA has made it clear that hospitals will have the opportunity to appeal an intermediary's determination of their base period old capital costs and hospital-specific rates. The recourse provided needs to be timely and outstanding appeals of capital-related costs should be processed before the transition begins.

Cost reporting changes.—Cost report changes will be needed corresponding to the new data required on capital, most notably to allow specific segregation of old and new capital assets. These changes clearly must be made as soon as possible.

CONCLUSION

Despite the requirements of current law, HFMA continues to believe that any policy change concerning Medicare payment for its capital costs is unnecessary and could harm hospitals, many of which are already in precarious financial conditions. However, unless the law is actually changed, Congress should make sure that HCFA's proposed payment system is modified as suggested in order to prevent as much harm to hospitals as possible. We offer our ongoing technical expertise throughout the process and appreciate this opportunity to make our views known.

STATEMENT OF KINETIC CONCEPTS, INC. (KCI)

We appreciate the opportunity to submit testimony for the written record for the hearing on the proposed prospective payment system for hospital capital payments held July 11, 1991, by the Finance Subcommittee on Medicare and Long-Term Care.

This testimony is submitted on behalf of Kinetic Concepts, Inc. (KCI) by James R. Leininger, M.D., President and CEO. KCI is a San Antonio, Texas based corporation with operations in all fifty states. KCI's basic business is the rental of moveable capital items to hospitals and other users of medical equipment. Through these rentals, KCI and other rental companies provide maximum flexibility for hospitals to manage their capital expenditures.

The rental of movable capital has not been part of either the abuses or shortcomings of the existing Medicare reimbursement system for capital. As we will explain below, rentals have been used by hospitals as an effective means of controlling capital expenditures and preventing the unnecessary purchasing or long term leasing of equipment. Rentals are utilized on an "as needed" basis, and are almost always connected to a specific patient need.

The purpose of our testimony is four fold. First, we will describe KCI's proposal concerning Medicare capital reimbursement for the rental of small-ticket medical equipment and discuss the rationale for this proposal. Second, we will comment on why the proposed capital regulation does not work and why it could limit beneficiary access to needed medical technologies. Third, we will suggest changes in the existing reimbursement regulation to ensure that our proposal, if adopted, is not abused. Fourth, we will discuss the nature of the rental market in general and why hospitals rent medical equipment in order to provide a more thorough analysis of the use of rentals to help control hospital capital expenditures.

KCI'S RENTAL BUSINESS

Most of KCI's rental equipment incorporates state of the art technology. This equipment includes specialty beds, ventilators, infusion pumps, incubators and cardiac monitors. These products are used in intensive care units and throughout the hospital to supplement or enhance an institution's resources.

KCI's rental equipment is used extensively by hospitals and skilled nursing facilities. These products help control costs by reducing patient days in intensive care units (ICU's) and by accelerating patient recovery time for various medical conditions.

Because of the technology incorporated into our equipment, the sales price ranges up to $40,000. Through renting, however, we are able to provide this equipment to hospitals that may have only an occasional need for this equipment for rental rates up to $100 a day. This is an extremely cost effective means of utilizing a hospital's limited capital budget compared to the leasing or purchasing of the same equipment.

Studies have demonstrated that our core rental item, specialty beds, can shorten by 50 percent or more the length of stay in an ICU for burn and other accident victims and reduce the length of stay for Medicare outlier patients with pressure sores. With the average daily cost in an ICU of $2,000 per patient, reducing stays by six to ten days can provide savings of $12,000 to $20,000. In short, rental of our beds saves money for Medicare, for hospitals and for patients.

RENTING VS. LEASING

Before going into our proposal, it is important to understand the difference between renting and leasing. A common mistake is to group rentals and leases together as similar transactions. Nothing could be further from the truth.

Leases of medical equipment are essentially financed sales. A particular piece of equipment or group of equipment is leased for a fixed period of time (generally at least one year). At the end of the lease term, the lessee has certain rights or obligations. The lessee, depending on the particular contractual obligation, must return the equipment to the lessor, purchase the equipment at a predetermined price, or guarantee a certain residual value for the used item. The lessee, however, is obligated to keep and pay for the leased equipment for the duration of the lease whether or not it is needed. This can result in the accumulation by hospitals of excess equipment and obsolete technologies.

Rentals of medical equipment, on the other hand, have no specific term. They are rented by hospitals for one day, for one week, or for whatever time period is needed. Once they are no longer needed, they are returned to the rental company with no further obligation. This helps prevent the accumulation by hospitals of obsolete technologies and excess equipment.

KCI's PROPOSAL

KCI proposes that the rental of small-ticket medical equipment (defined as equipment priced under $65,000) continue to be reimbursed on the basis of reasonable cost for disproportionate share, teaching, and rural sole community hospitals, rather than folded into the proposed prospective payment system for capital expenditures. We suggest a reimbursement rate of 90 percent for this exception to maintain the budget neutrality of the overall proposed regulation.

Further, to prevent hospitals from over-utilizing this rental exception, Medicare rental payments would only be made: (1) for a medical equipment item or category of items currently reimbursed under Medicare's capital payment rules; (2) if the rented medical equipment was designated for a specific medical need; and (3) subject to a cap equal to five percent of the hospital's previous year's Medicare capital reimbursement.

The objective of this proposal is to provide an additional revenue source for accessing capital by these hospitals that is targeted and provides for cost efficient capital spending and is in line with the basic objective of the proposed prospective payment system.

RATIONALE FOR THIS EXEMPTION

The use of rentals helps hospitals do what they do not normally do under other circumstances because of liability concerns and competitive pressures: share and pool capital resources. With rentals, the problem of oversupply and obsolescence, as well as maintenance and repair costs are shifted largely to the rental companies. The net result is an effective pooling of resources that reduces total capital expenditures by all hospitals. Rentals also allow hospitals to respond in a cost effective manner to census fluctuations and unusual patient and treatment needs.

Simply stated, the current system works for rentals and is already furthering the goal of the proposed capital regulation: to limit the growth of capital-related expenditures by hospitals. As such, the continued use of rentals by these three types of hospitals will provide them with an additional source of funds that is completely consistent with the proposed prospective payment system for capital.

Numerous concerns have been raised about the ability of teaching, disproportionate share and rural sole community hospitals to be adequately reimbursed for their capital costs under the proposed capital regulation. Because these hospitals have historically experienced higher operating and capital costs per patient than other hospitals, the new regulation may make it difficult for them to make necessary capital expenditures.

HCFA's own simulations show major teaching hospitals, as a group, will be one of the consistent "losers" under the proposal, reimbursed at an average of three percent below their actual capital costs per case.

Disproportionate share hospitals are also characterized as "losers" by HCFA under the proposed regulation. Studies have shown that low-income patients use a disproportionate amount of resources on a per diem basis, and therefore hospitals serving large numbers of such patients require additional payments.

Under the present capital rules, sole community hospitals are exempt from the discounted capital reimbursement rate imposed on most other hospitals. The proposed rule would have the effect of including sole community hospitals in the proposed prospective payment system. After the transition period they would be treated like all other hospitals. As a result, the proposed rule erodes the protection offered to sole community hospitals and may ultimately jeopardize the availability of care in rural areas.

Given HCFA's own conclusions, and given the fact that the American Hospital Association's simulations show even more "losers" than HCFA, there is every reason to fear that capital reimbursements will be inadequate for these three types of hospitals. As a result, many of them will be forced to use all of their Medicare capital revenue to meet existing capital obligations, leaving no funds to pay for rental items to meet Medicare beneficiaries' medical needs.

Congress has traditionally provided additional payments to these hospitals for their operating costs under the DRG system. ProPAC testified at the hearing that the perspective payment system should contain adjustments just as the system currently provides for adjustments for operating costs for teaching, disproportionate share, and rural sole community hospitals. Further, there is a growing consensus that some additional payment needs to be provided to these hospitals so that they are not unfairly disadvantaged by the new capital regulation. A targeted rental exception can provide additional funds to these hospitals in a manner that is efficient and enhances patient care.

THE PROPOSED REGULATION MAY NOT ALLOW THESE HOSPITALS TO ACCESS EQUIPMENT THROUGH RENTALS

Under the proposed regulation, rentals are disadvantaged because, by the nature of their short term duration, they will only be reimbursed under the definition of "new" capital. As most of the money in the regulation will go towards reimbursement for "old" capital, we are concerned that the total amount set aside for "new" capital simply will not be enough to meet these hospitals "new" capital costs. This is particularly true for teaching, disproportionate share and sole community hospitals.

Also under the proposed rule, these hospitals will only be paid under the federal portion of "new" capital, which is even a smaller sum of money. Even ProPAC has testified that they believe "the 1992 Federal rate of $472 is too low because it was based on assumptions of low growth in capital costs from 1988 through 1991 and large increases in Medicare admissions." In other words, these high capital cost hospitals will not receive adequate capital payments. As a result, they will have to use their capital payments for existing capital obligations. Therefore, they will not have the funds available for necessary rentals, limiting beneficiary access to the latest technologies.

Further, hospital rentals may be hurt because rentals are not distinguished under the hospital specific rate. If these hospitals do not have a history of renting equipment, it may be difficult to use rentals with the funds allocated to these hospitals under their specific rate.

Also, because of the short term nature of rental agreements, rentals, unlike leases, will not be covered under the "hold harmless" provision. Therefore, the rental market will be disadvantaged for those hospitals that avail themselves of the hold harmless provision.

The development and growth of the rental industry for medical equipment is a relatively new phenomena, and the rental of small ticket equipment has been growing substantially in recent years. As a result, neither the proposed calculation of new capital nor the hold harmless calculations adequately take the rental market into account and will not create incentives for prudent hospital rentals. Instead, the opposite will only be too true for high capital cost hospitals like teaching and disproportionate share hospitals.

The current reimbursement system for hospital rental equipment does precisely what the proposed rule is intended to do: create an incentive for hospitals to make wise decisions about their capital expenditures. With the language we suggest to tighten the rules for rental reimbursements, hospitals will be unable to overutilize rentals while all of the incentives for prudent rentals will be maintained.

SUGGESTED CHANGES TO THE CURRENT REIMBURSEMENT REGULATIONS TO PREVENT THE ABUSE OF THE RENTAL EXCEPTION

The current Medicare regulation at 413.130 concerning rentals is effective in ensuring that rentals are only reimbursed when they are cost effective. However, once a perspective payment system is in place for capital, with a rental carve out for disproportionate share, teaching and sole community hospitals, there will be a need for a more tightly controlled reimbursement for rental medical equipment to prevent any potential abuse of this exception.

Under the present regulation, for a rental to qualify as a capital cost, the provider must have possession, use, and enjoyment of the asset. The regulations also stipulate that a provider can only claim Medicare reimbursement for a rental item when three conditions are met: (1) the rental charges are reasonable based on consideration of (a) rental charges or comparable facilities and market conditions in the area, (b) the type, expected life, condition, and value of the facilities or equipment rented, and (c) the other provisions of the rental agreements; (2) adequate alternate facilities or equipment that would serve the purpose are not or were not available at lower cost; and (3) the leasing was based on economic and technical considerations.

The regulation goes on to state that, if these conditions are not met, a provider may include in its capital-related costs only the amount "which the provider would have included in capital-related costs had the provider retained legal title to the facilities or equipment..." In other words, the current regulation provides safeguards to the over use of rentals by requiring that Medicare reimburse fully for rentals only when they are cost effective.

If a rental exception for these hospitals is adopted, we would suggest several modifications to these regulation to ensure that this exception is not abused. First, it should be made clear that these hospitals should only be reimbursed for a medical equipment item or category of items currently reimbursed under Medicare's capital payment rules. For example, KCI's specialty beds for trauma and pressure sore patients are currently reimbursed under Medicare's capital pass through. Under this proposal hospitals would continue to be reimbursed for 90% of their costs for these

specialty beds. KCI could continue to improve the technology without having to worry that a specific item would only be reimbursed because the regulation would cover categories of equipment. While it can be argued that this language is not needed, it will help prevent these hospitals from claiming reimbursement for rental equipment which are not presently considered capital expenditures.

Secondly, we suggest that the regulation be amended so that these hospitals can only be reimbursed if the medical equipment is designated for a specific medical need. This will prevent these hospitals from renting equipment for longer periods of time then is required to meet the patient's need and will preclude the hospitals from being reimbursed for unused or idle rental equipment.

Thirdly, to further prevent over-utilization of rentals, we would propose that a cap be placed on rental reimbursement so that teaching, disproportionate share and rural sole community hospitals could only be reimbursed for an amount equal to 5% of the hospital's previous year's Medicare capital reimbursement.

Adding these three conditions to the current reimbursement regulations will preclude these hospitals from abusing the cost based reimbursement system we propose. Instead, appropriate incentives for hospitals to rent when it is cost efficient will be maintained without creating a loophole for hospitals to over-utilize the system.

DESCRIPTION OF THE RENTAL BUSINESS

To appreciate the role of rentals in controlling capital expenditures, it is appropriate to discuss the rental business and current use of rentals as a capital management technique in further detail.

Because of their inherent characteristics, rentals are used effectively by hospitals to manage and control capital expenditures and to avoid either the purchasing or long term leasing of equipment in instances where a long term commitment is imprudent. Rentals can also eliminate the need for hospitals to provide the many specialized services necessary to maintain, clean and sterilize a wide variety of highly complicated medical equipment.

KCI and other rental companies can rent equipment at deep discounts because of volume purchases and pass these savings on to hospitals. We can also shift inventories geographically to achieve greater utilization of existing equipment.

Rentals provide a pool of equipment available to hospitals on an "as needed" basis. As a result, hospitals need not purchase equipment to meet peak demands that would remain idle or under-utilized during lower census periods. This pool would probably not be available without a strong rental market, since hospitals traditionally have had difficulty sharing equipment among institutions because of liability problems, natural distrust and repair and maintenance concerns. Because of these problems, renting makes the concept of pooling viable.

Through our experience in dealing with hospitals, we have found that many institutions either discard or permanently store perfectly good medical equipment. Often, this is done simply because of a desire to shift to a different brand name or because of the personal preference of physicians. Rental companies such as KCI often purchase this equipment in bulk, returning it to the rental pool or selling it to health providers in lesser developed countries. In addition to keeping this capital in circulation, these transactions also provide funds for hospitals from the sale of otherwise unused equipment.

An efficient rental market also helps manufacturers develop and market new technologies in a cost effective manner. Rental companies allow manufacturers to disperse equipment throughout the country without having to establish a sales fleet and distribution network. This is particularly important for the many small businesses that have produced significant technological developments in medical equipment.

While the rental market for medical equipment has existed for a long time, it is only recently that it has grown to the degree that it can offer hospitals a substantial capital management capability. This continued growth is necessary in order for rentals to provide the maximum effectiveness in allocating capital in the most efficificient manner possible.

WHY HOSPITALS RENT MEDICAL EQUIPMENT

The rental industry has developed in direct response to diminishing access to capital and the subsequent need to better manage capital outlays. Hospitals currently use rentals as an effective and efficient tool for managing capital expenses. Rentals transfer the risk of obsolete or under-utilized equipment from the hospital industry back to the rental company.

Rentals provide an ideal response to census fluctuations, new or changing technologies, unusual patient and treatment needs, and unforeseen emergencies. Many hospitals now turn to rentals as a temporary means of "flexing" their existing inventories without being compelled to purchase assets that would be under-utilized. Rentals also allow hospitals to experiment with new technologies while eliminating the risk of inappropriate acquisitions.

Hospitals also use rentals to try out new technologies before committing to purchases or long term leases. Instead of purchasing a specialty bed for $25,000, a hospital can rent the bed for $25 a day while the exact needs of the institution are assessed. Through rental, costly purchasing mistakes can often be minimized or avoided.

It is prudent for HCFA to promote the use of rentals as a means of advocating a pooling of resources by hospitals. The appropriate use of rentals helps hospitals do what they do not normally do under other circumstances because of liability concerns and competitive pressures: share and pool capital resources. With rentals, the problems of liability, oversupply, and obsolescence as well as maintenance and repair costs are shifted largely to the rental companies. The net result is an effective pooling of resources that reduces total capital expenditures by all hospitals.

Because of these characteristics, the use of rentals is already furthering the goal of this proposed regulation: to limit the growth of capital-related expenditures by hospitals. It is imperative, then, that this proposed rule not limit the effectiveness of the rental market to help control unnecessary capital expenditures while maintaining access to the latest technologies.

"OLD" VS. "NEW CAPITAL"

We understand that several witnesses at the hearing want to expand the definition of so-called "old capital" to include long term leases, taxes, insurance and home office capital costs. Since rentals fall entirely into the category of "new capital," we are concerned that any expansion of the definition of "old capital" not be financed by reductions in funds available to "new capital." Instead, an expansion of the definition of "old capital" should be accommodated within the pool of funds already provided for "old capital."

CONCLUSION

We are requesting a budget neutral proposal that would allow Medicare to continue a pass through for the rental of small ticket items to be reimbursed at a rate of 90 percent under the cost based reimbursement system for teaching, disproportionate share and rural sole community hospitals. Only by this approach will these hospitals continue to have both the incentive and ability to rent when it is cost effective, but not overutilize this option.

The current rental reimbursement system ensures these hospital's access to the best technologies for Medicare beneficiaries at a cost effective price. The current system also allows them to pool their resources and share state of the art equipment through rentals, shifting the problem of obsolescence and over supply to the rental industry. This system is working and should be maintained.

Once again, we appreciate the opportunity to submit this testimony for the written record.

Statement of the National Council of Health Facilities Finance Authorities

I. INTRODUCTION

A. Health Facilities Finance Authorities

The National Council of Health Facilities Finance Authorities ("Council") is the national association of the 26 public authorities that issue tax-exempt revenue bonds for not-for-profit and public health care facilities on a State-wide basis. The authorities were created by State legislation and are governed by boards, typically appointed by the Governor with the consent of the State Legislature, which often include State officials such as the Governor, Treasurer, and Commissioners of health, public aid, insurance, human services, taxation or budget. Members of the Council issue about two-thirds of all tax-exempt hospital bonds in the U.S.

The authorities were created to raise affordable capital to provide modern, well-equipped, high quality health care facilities at the lowest possible costs. Tax-exempt bond proceeds are used for modernization, renovation or replacement of obsolete or otherwise inadequate facilities, reconfiguration of facilities to provide lower cost services, necessary capacity expansion, acquisition of new medical technologies, and refinancing of costly taxable debt.

The Council, therefore, approaches the proposed prospective payment system for inpatient hospital capital-related costs ("proposal") from the perspective of larger projects financed by long-term debt, e.g., major modernization, renovation, or replacement projects, in urban and rural areas, including teaching hospitals, medical centers, and multi-facility projects.

B. Council Conclusions and Position on Proposal

Unfortunately, it appears that relatively few hospitals have completed a thorough, long-term analysis of the impact of the proposal on their future projects. This is primarily because of uncertainty about the operation of the proposal after the first few years—a crucial issue in determining the impact of proposal on 30-year debt obligations—and the difficulty in projecting capital needs far in the future. As more hospital-specific information becomes available, we may supplement this comment.

Sufficient information does exist, however, for an analysis of the impact on projects already financed and on some future projects of the proposal and various modifications of the proposal, and for the formation of our conclusions and recommendations.

The Council conclusions regarding the proposal are:

1. Despite the improvements over the proposals made in 1986 and 1987, the 1991 proposal would seriously under-reimburse capital costs for needed projects, misallocate capital between hospitals, and result in a less effective and efficient health care system. Under the proposal:

a. Many hospital facility projects needed by communities will be precluded or significantly downsized, delayed, or made more expensive; and

b. Some hospitals will be forced to default on existing obligations, thus eliminating the possibility of future financing for those hospitals and either eliminating or substantially driving up the costs of capital for other hospitals.

2. The present system, although imperfect, allocates hospital capital where it is needed and a major change of the type proposed is unjustified on policy and budgetary bases; and

3. If a prospective system is adopted, the proposal must be modified to reduce to the extent possible the adverse effects of imposing such a system on the health care system.

In sum, we believe the proposal would frustrate the basic purpose for which health care finance authorities were created—to provide low-cost capital for needed health care facilities. For this reason, we strongly oppose the proposal and request that HCFA reduce its adverse impacts by adopting the recommendations made below.

II. OPERATION OF PROPOSED PROSPECTIVE SYSTEM AND CURRENT CAPITAL ALLOCATION SYSTEM

A. Prospective System Is Fundamentally Inconsistent with Capital Costs, Especially for Not-For-Profit Hospitals

After analyzing the proposal and attempting to devise modifications or alternatives to it that would provide adequate reimbursement for needed capital projects, we have reluctantly concluded that a prospective payment system is fundamentally incompatible with appropriate hospital capital cost reimbursement. This is because any prospective system is based on the national average of capital costs for hospitals in very different capital cost circumstances in any particular year. A system based on such an average that would adequately account for legitimate differences in capital costs has not been proposed, is beyond our ability to construct, and may be theoretically impossible.

The prospective payment system for operating costs cannot be used as a model for adequate capital cost reimbursement because capital costs are fundamentally different from operating costs. Of course, any payment system based on averages will not be totally accurate in reimbursing legitimate cost differences for each event creating the costs; it will over-reimburse some events and under-reimburse others. The amount of inaccuracy can be reduced with adjustments for different circumstances and the adequacy of the adjusted payment will depend upon the extent to which the adjustments correlate to the reasons for legitimate variations in cost.

For prospective operating payments, the adjustments used appear to deal with a substantial amount of the legitimate variations in operating costs. In addition, the remaining inaccuracy in the prospective payment rates tend to balance out because each hospital has a large number of events (discharges) for which costs are incurred over its annual accounting period.

This is not the case for capital payments, where events involving major capital expenditures occur very infrequently and the consequent major differences in capital costs incurred span many accounting periods.

Any capital reimbursement program based on a national average capital cost for a hospital with average capital needs at the average point in its capital cycle and with average financing costs will have large variations from actual, legitimate capital costs that are time-dependent. These variations are principally a function of the position of the hospital in its capital cycle and its financing costs, including the interest rates applicable to hospital bonds and the prevailing construction costs when and where the project was needed and undertaken. The proposal totally fails to account for these time-dependent differences.

In addition to these time-dependent factors are time-independent factors which the proposal attempts to account for with various adjustments from the Federal rate. However, the factors that explain legitimate differences in capital costs are different in type or degree than those that explain legitimate differences in operating costs on a per-discharge basis. The proposal inadequately adjusts for these differences, apparently in an attempt to use only the same factors now employed to adjust operating payments.

This system is particularly incompatible with not-for-profit institutions which have very limited options to deal with inadequate capital reimbursement. A for-profit corporation may respond to inadequate revenues for needed modernization or other capital programs by selling the facility and moving its capital to another location where a higher return may be earned or by issuing equity to reduce its debt

service costs. A community-based not-for-profit institution, such as a hospital, cannot move and cannot issue equity. Also, unlike a public institution, it cannot levy taxes to fund its capital deficit. Not-for-profit hospitals, the backbone of our health care system, are thus particularly hard hit by the proposal.

1. Defaults of Existing Obligations: Higher Cost

The proposal would not treat as "old capital" a substantial amount of tax-exempt bonds issued in the last three years that would not be contained in FY 1990 cost reports. It also would not treat lease and other obligations currently reimbursed as old capital. Finally, it would provide hold-harmless protection to old capital only for a 10-year transition period, when hospital bonds are typically issued for 30-year terms. The special rule for recent capital commitments, which would continue to treat post-1990 capital as new capital, would provide little additional relief.

The proposal will result in major reductions (either during or after the transition period) in capital reimbursement for many hospitals with outstanding debt obligations. Any significant reductions in reimbursement for outstanding debt obligations could result in defaults. Although capital payments only represent about 10 percent of operating payments, for the many hospitals with zero or negative operating margins an adequate capital payment is essential to meet their debt service obligations.

There is no fat in the operating payment system to subsidize inadequate capital payments. Many hospitals may be required to reduce patient services and the quality of care to fund inadequate capital reimbursement and avoid default.

Hospitals with the least ability to subsidize inadequate capital payments with surplus operating payments are those that use FHA mortgage insurance. For issues guaranteed under the FHA mortgage insurance program, the short-term impact of increased defaults will be to stress severely the insurance fund. The long-term impact will be to make it more difficult and more expensive for hospitals to get FHA mortgage insurance.

The impact will be even more severe for private bond and mortgage insurance, which typically only insures issues with extremely low risk to improve credit ratings and lower interest rates. This will create even more demand for FHA insurance at the same time FHA will be weakened and less able to provide such insurance. Together, these developments will at best increase the cost of capital and at worst preclude needed projects for financially weaker hospitals.

Defaults, especially of bonds that are not insured and that cause bondholder losses, will reverberate through all hospital financings in the form of increased interest rates to compensate bondholders for the increased risk of defaults. Reduced capital reimbursement for high capital cost hospitals will also result in hospital ratings downgrades. Ratings downgrades outnumbered ratings upgrades by a ratio of three to one in 1990, following several years of where downgrades exceeded upgrades, with the maximum downgrade ratio of 12 to one in 1986 when major reductions in Medicare operating payments were undertaken. Increased interest rates will be demanded by bondholders to compensate them for the increased risk of default on new bond issues. Of the major categories of municipal bonds, hospitals now must pay the highest interest rates for a given bond rating because of the perceived higher risk of such bonds, and this proposal would only make matters worse and further increase hospital capital costs.

In sum, for many hospitals the proposal will increase risk and thus capital cost (with an immediate adverse effect on hospitals with variable rate debt) and simultaneously reduce capital reimbursement. Hospitals may attempt to shift substantially increased health care cost to non-Medicare payers, but the increasing use of managed care systems will make this difficult, with the likely outcome being a reduction in operating funds for patient services.

2. Misallocation of Capital: Reduced Effectiveness and Efficiency

The proposal would result in a massive reallocation of hospital capital reimbursement funds, and ultimately of both the amount and distribution of capital in the health care system.

The proposal would shift funding from hospitals that have much larger than average capital needs to those that have much lower than average capital needs. we believe that in the vast majority of instances, the current differences in capital per discharge are justified on the basis of community need, and the hospital's position on the capital cycle and its financing costs. A substantially different allocation would reduce the effectiveness and efficiency of the health care system.

In addition, despite statements that the proposal would not change the aggregate amount of capital costs paid hospitals, we believe that the proposal will have the net effect of shifting funds from capital to operating budgets, thus hiding inadequate operating reimbursement and further weakening the hospital system in the long term.

This would occur because hospitals that receive capital payments in excess of their current capital cost needs and that have operating deficits are very unlikely to save these funds for several years to provide equity for a future capital project. Rather they will use these funds to offset operating deficits in the current year, leaving nothing for future capital projects. when those projects are needed, they will not occur (assuming the hospital does not have sufficient operating surpluses in the future to subsidize inadequate capital payments.)

For a hospital with average capital costs today the prospective payment would exactly cover its debt service cost. It would, therefore, have no excess capital payments to save and would not be able to begin saving funds for future projects, until its current debt obligations are retired. This may result in a very long period between the time a project is needed and existing obligations are paid and sufficient excess capital payments have accumulated to allow the project to go forward. In addition, as discussed above, the likelihood of a hospital saving any excess capital payment is questionable except for hospitals in the strongest financial position. Hospitals with above-average capital costs would have the same problem.

Hospitals with below average capital costs today, and which do not need average amounts of capital, would receive a subsidy that could be used to offset operating cost deficits or for any other purpose.

Hospitals with below average capital costs today, and which are about to embark on a needed major capital program, would have to delay the project until sufficient excess capital had been saved to reduce the amount needed to be financed, and therefore the required debt service, to the amount that would be reimbursed under the proposal.

Although the proposal contains adjustments that attempt to account for legitimate differences in capital needs, our analysis shows that these adjustments in fact will account for only a small amount of the legitimate variation in capital costs. Below we suggest modifications of these adjustments that would improve the accuracy of the prospective payment system in reimbursing actual capital costs. However, without a permanent and expanded exceptions payment, the Federal rate, even with these adjustments, will be inadequate and unfair in many cases.

B. The Current System Operates Better Than Would the Proposal

The current system, although imperfect, allocates capital better than the proposed system would. we believe that hospital capital projects financed by tax-exempt revenue bonds now correlate very closely to community needs for the facilities financed. Projects not needed by the community, those that would result in surplus capacity, generally would not generate revenues sufficient to meet debt service obligations, even with Medicare capital payments on a pass-through basis, and therefore are not financed with tax-exempt debt.

A more serious problem under the current system is the difficulty in financing needed projects of financially distressed hospitals. However, States are now responding to this problem with State bond insurance programs, distressed hospital funds, and other mechanisms that complement revenue bond financing.

The present system for allocating hospital capital for larger projects that involve debt financing includes numerous controls that strongly discourage or eliminate debt financed projects that are not necessary to meet community health needs. These controls include:

1. Federal tax-exempt bond rules, which more heavily regulate not-for-profit than public institutions (and which do not apply to for-profit institutions at all) restrict the permitted uses for bond proceeds to the exempt purpose of the institution, require public hearings on the projects prior to bond issuance, and impose other requirements.

2. State and local legal requirements regarding the permissible uses for bond proceeds and, in some States, Certificate of Need programs and other public approval processes for bond-financed projects, or State rate-setting programs requiring prior approval for capital projects.

3. Federal and State reimbursement regulations imposing limits on capital reimbursement directly through below-cost reimbursement and indirectly through inadequate operating reimbursement. After over $100 billion in reimbursement reductions to lower the deficit, typical hospital margins are negative and projected to be more so. These deficits restrain capital spending because capital is not fully reimbursed under the cost-minus payment system now in place and surpluses must be available from operations to subsidize capital costs.

4. Private payor reimbursement restrictions, through negotiated capital reimbursement rates which put hospitals with excessive capital costs at a disadvantage

in competing for the patients of large employers, unions, and various types of managed care systems.

5. Market restraints are imposed through feasibility studies, which must show a project will earn sufficient revenues, based on the community need for the facility, to make payments on these "revenue bonds," and on the assessments of rating agencies, and ultimately bond buyers, regarding the ability of the hospital to repay the debt.

6. Hospital trustees have legal obligations to manage the assets of the institution prudently, which includes not encumbering its assets to borrow funds to produce facilities not needed by the community and, therefore, which may jeopardize the continued existence of the institution.

7. Health Care Finance Authorities, whose boards (described in the Introduction above) are concerned with the negative impact from a default caused by overexpansion of facilities on the State's bond rating and the Authority's continued ability to finance other projects, may exercise significant control over what projects are financed, even where default is not a concern.

We believe that there is much evidence that these controls are effective:

1. Tax-exempt bond issuance for hospital construction and equipment acquisitions (adjusted for construction cost inflation) has been generally stable over the last several years, and was lower in 1990 than in 1989. See the attached chart for 1982 to 1990 new money hospital bond issuance. (Note: the unusually large amount issued in 1985 was in response to tax reform legislation passed in the House that would have substantially reduced hospital bond issuance; it appears that the 1985 issuance over the average was absorbed in 1986, 1987 and 1988, with 1989 and 1990 returning to the average level of issuance.)

2. Medicare inpatient capital-related cost data and projections of future Medicare capital costs show that such costs are under control, have declined since 1984, and are projected to be stable at much lower rates than in the mid-1980s. See that attached analysis by the Catholic Health Association.

Although these controls are not perfect and their impact varies between States and individual hospitals, our experience is that the system works remarkably well at financing only needed facilities.

Any major change in the system for allocating hospital capital should be based on a careful analysis of patterns of capital misallocation under the current system and should be shown to result in an improvement in the effectiveness or efficiency of the health care system. The proposal does not meet either of these tests.

C. No New Financing Methods To Accommodate Proposal

The proposal states that new financing methods can be developed to accommodate inadequate prospective payments for hospital capital and thus avoid some adverse impacts of the proposal. There are four alternatives for dealing with inadequate capital payments: (1) reduced interest rates; (2) extend maturities; (3) break larger projects into a series of smaller projects; or (4) sell the asset and find a more productive use for the capital.

We do not believe any of these methods would be effective for not-for-profit hospitals and have not been able to devise any novel financing methods that would effectively counterbalance drastically reduced capital reimbursement for hospitals that depend on that payment to make a financing feasible. For example:

1. As discussed above, the proposal will increase interest rates for hospital bonds. Attempting to lower interest rates by issuing short-term, variable-rate debt rather than long-term, fixed-rate debt would result in more risk to the hospital, particularly under a prospective payment system where increased interest payments due to increased—interest rates would not be reimbursed. Once payments for interest rate caps are included in the cost of this type of debt, there is little net savings to the borrower. Uncertainty about the direction and timing of future interest rate movements usually precludes delaying a project in the hopes that rates will decline.

2. Extending the maturity of hospital bond issues beyond the present 30 years would result in maturities in excess of useful lives of the assets financed and would increase overall interest payments. Tax law restrictions also limit the issuer's ability to extend bond maturities.

3. Larger projects generally cannot be effectively or efficiently broken down into smaller projects because of the interdependent nature of hospital facilities.

4. As discussed above, community-based not-for-profit institutions do not voluntarily move to another location, although they may be forced to close their doors.

The only significant adjustment in financing that we believe could occur, even in theory, is for hospitals with very low current capital costs to save excess capital payments until they need to undertake their next capital project and then use these funds to provide sufficient equity to reduce the financed amount to the point where the prospective payment would cover the new capital cost. As discussed above, we do not believe that this will occur very often.

III. RECOMMENDATIONS

We have reviewed the recommendations made by the American Hospital Association, Catholic Health Association, and other hospital groups and we support these proposals. They would result in a prospective payment system with substantially reduced adverse impacts on the health care system. Based on our modelling of debt-financed hospital capital projects, we suggest the following modifications of the proposal (which are consistent with the recommendations of the hospital industry).

By far the most important recommendations in avoiding the most adverse impacts of the proposal are those dealing with the permanent old capital hold harmless provision and the permanent exceptions floor.

A. Hold Harmless and Exceptions Process Must Be Permanent

The special rules in effect during the transition period are virtually irrelevant for major projects financed with long-term debt. Any protection for past or future debt obligations must be permanent to be effective.

Existing long-term debt obligations, such as the roughly $10 billion in tax-exempt bonds issued for public and not-for-profit hospitals in 1990, will still be outstanding in 2001. We do not believe that a hospital with such debt will be able to conform its operations during a 10-year transition so as to avoid a significant underpayment for such outstanding obligations, and possible default, at the end of the transition period. Therefore, any hold harmless provision for old capital should be made permanent.

In addition, any project under preliminary consideration today would not come on line until the last half of the transition period. In New York State, for example, it takes two to three years to complete the CON process and another two to three years after the financing to complete the project. urge projects take even longer. For example, a major teaching hospital in New York City received an effective CON in 1983, but the last phase of the project will not get onto the hospital's Medicare cost report until 1992.

Any special treatment for such a project under an exceptions process only applicable during the few remaining years of the transition would be of little consequence compared to the inadequate reimbursement for the remaining term of 30-year bonds. Therefore, any exceptions process must be permanent to be effective for future issues.

B. Old Capital Hold Harmless

The proposal should be modified to prevent defaults of outstanding debt obligations, as follows:

—"Old capital" should be defined to include all obligations for debt that are legally binding (bond purchase agreements), any advance refundings of old capital, official action by the issuing authority (the approval of a bond resolution), and all other legally binding commitments for costs that are currently reimbursed (such as leases and off-site capital) entered into by the effective date of the final rule;

—"Hold harmless" treatment (at 90 percent of actual costs) should be provided for old capital until such obligations are met, not merely during a limited transition period.

C. Exceptions Floor

A permanent exceptions process providing a floor of at least 80 percent of actual capital costs (including of the costs currently reimbursed), and a higher level for sole community providers, would achieve the goals of the proposal while avoiding major adverse impacts on certain projects. It would allow major modernization programs for very old facilities that have delayed renovation or replacement projects and that require significant amounts of new technology. It would not involve a major increase in the percent of actual costs paid under the proposed exceptions system (which have been estimated as the equivalent of a 67 percent floor) and would be substantially simpler to operate.

This "cost-minus-20 percent floor" would further reduce (in many cases inappropriately) capital expenditures. As discussed above, the current cost-minus-15 percent

payment, in conjunction with tight DRG payments reductions for operating payments, is already effective in controlling capital investments.

D. Modifications Of Federal Rate Adjustments

After the modifications of the old capital hold harmless and permanent exceptions process discussed above, the most important modifications that should be made in the proposal are the inclusion of additional adjustment factors that most strongly correlate with legitimate capital costs:

1. *Asset Age:* the ratio of national average asset age to hospital-specific asset age should be an additional adjustment. This factor explains more of the differences in capital costs than any other.
2. *Financing Method:* the hospital's reliance on and cost of debt should be considered (and is necessary to put not-for-profit hospitals on a level playing field with for-profit hospitals that can issue equity and public hospitals that can levy taxes); where the hospital's debt to equity ratio exceeds a specified level, a set adjustment factor should be provided. Our modelling efforts to date suggest that the trigger level should be a debt/equity ratio of 1.35 and the adjustment factor should be 1.2.
3. *Teaching Status:* Our experience is that teaching hospitals do and should have higher capital costs than non-teaching hospitals with the same case mix index, location, and other factors. Some additional adjustment should be provided.

In addition, the adjustments to the Federal rate contained in the proposal should be revised as follows:

1. *Case Mix Index:* The adjustment factor should be increased twice the amount of the case mix index increase. The case mix reflects both how long; a patient uses the facility's capital assets and how much of the facility's expensive capital assets are used.
2. *Disproportionate Share:* The adjustment should be increased the same amount for capital as for operating costs.
3. *Geographic Location:* All areas deemed urban by Medicare should receive the urban area adjustment, and other indices in addition to the wage index should be used to more accurately match construction costs with capital costs.

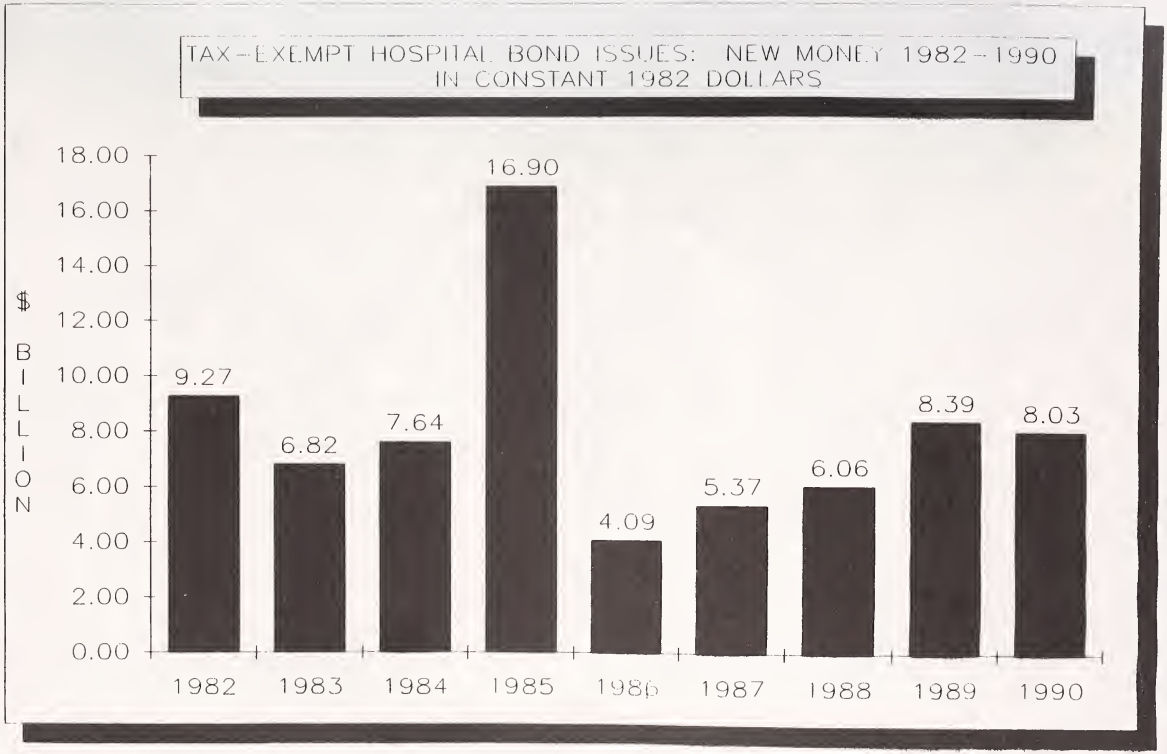
E. Payment Updates

The update factors provided by HCFA to the hospital industry to enable hospitals to assess the impact of the proposal should be formally adopted as part of the proposal.

IV. CONCLUSION

We understand that HCFA has been directed by Congress to implement a prospective capital payment system and we appreciate the effort of HCFA to devise a workable system. We strongly recommend that HCFA adopt the modifications to its proposal described above to reduce the adverse impacts on the health care system of the proposal.

Even with these changes, however, we believe that the prospective system will unjustifiably reduce the effectiveness and efficiency of the health care system. If this system is implemented, we believe Congress will be called on to rescue individual hospitals forced decreases the access to or quality of care because of inadequately reimbursed legitimate capital costs.



Sources: Publicly and privately placed bonds with maturities over 1 year for public and private not-for-profit hospitals; non-hospital health care facilities such as clinics, medical office buildings, nursing homes, and continuing care facilities are included for 1982-1984 only. Securities Data Co./Bond Buyer. Costs adjusted to 1982 dollars by E.H. Boeckh building cost index for apartments, hotels, and office buildings; average of 20 cities for types shown; weights based on surveys of building costs. U.S. Department of Commerce, International Trade Administration, Construction Review, bimonthly.

48-319 (136)

Increases in Inpatient Capital Related Costs Under Medicare's Hospital Insurance Program Fiscal Years 1984-1995**

**with percent reduction mandated '86, '87, '88, '89, '90, '91, '92

Fiscal Year	Aggregate[1] Payment (Billions*)	Year/Year[1] Percent Increase	Number of cases 000's	Payments[1] per case	Year/Year[3] Percent Increase	Capital[2] Market Basket	Yr/Yr %[3] Incr. cap. cost per disch. adj. for cap. mkt basket	Year/Year[4] Changes in real case mix	Yr/Yr %[3] Incr. in cap. cost per disch. adj. for chage in cap. mkt bskt + real case mix
1984	3.724	n/a	11517	325			n/a		
1985	4.241	13.9	10834	390	20.0%	6.3%	12.9	2.33	10.3
1986	4.705	10.9	10591	445	14.1%	4.6%	9.1	.9	8.1
1987	5.059	7.5	10281	490	10.1%	2.9%	7.0	2.1	4.8
1988	5.224	3.3	10124	515	5.1%	1.9%	3.1	2.4	.7
1989	5.360	2.6	10261	520	1.0%	.5%	.5	2.3	-1.8
1990	$5.852	9.2[a]	10415	565	8.7%	.9%	7.7	2.2	5.4[a]
1991	$6.394	9.3	10660	600	6.2%	1.3%	4.8	1.5*	3.3
1992	$7.420	16.0[b]	10968	677	12.8%	1.6%	11.0[b]	1.5*	9.4
1993	8.254	11.2	11279	732	8.1%	2.4%	5.6	1.5*	4.0
1994	9.121	10.5	11594	787	7.5%	2.9%	4.5	1.5*	3.0
1995	10.080	10.5	11904	847	7.6%	3.0%	4.5		3.0

[a] A substantial portion of this jump is due to the fact that in FY '90 the 15% reduction was applied to only 3/4 of the year.

[b] 3.0% of this increase is due to reducing the percentage reduction from 15% in FY '89 to 10% in FY '90.

*Assumes continuation 1.5 percent increase in real case mix

Source:

1 Congressional Budget Office, January 1990, baseline adjusted for CBO estimates of OBRA '90 estimates

2 Office of the Actuary

3 Calculations by Catholic Health Association $\frac{1.20}{(1.063} = 1.129 = 12.9\%)$

4 ProPAC's annual recommendation to the Secretary

Prepared by the Catholic Health Association.

3 8095 00012687 6
CMS LIBRARY